**Routine and Preventative Services Healthcare Plan**

| **Name:** | FirstName LastName | | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- | --- |
| **These are my medical diagnoses:** | | List all diagnoses. | | |
| **I am allergic to these things:** | | List all known allergies and sensitivities, or note if there are none | | |
| **The goal of this Healthcare Plan is:** | | I will remain free of preventable health conditions by receiving routine healthcare services, immunizations, and follow-up on time, for the duration of the ISP year.  Describe any other goal related to my routine and preventative services. | | |
| **Progress in the past year:** | | Describe the status of my preventative and routine services in the past year, including whether any recommended procedures were not completed. | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY if I:**  **🡪 Have a reaction after any exam or diagnostic procedure (with or without sedation), including loss of consciousness or change in mental status.**  **🡪 Describe any additional instructions here.** | | | | |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL**  **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | | |
| **These are the IMMUNIZATIONS I should receive regularly:** | | **Flu Shot** every year in indicate month or season flu shot is to be received.  **Tetanus shot** every ## years. Date of most recent tetanus: ##/##/##  **Pneumonia vaccine** every ## years. Date of most recent pneumonia shot: ##/##/##  **Varicella vaccine or titer** every ## years or as ordered. Date of most recent varicella vaccine: ##/##/##  **Hepatitis A vaccine or titer** every ## years or one series. Date of most recent series: ##/##/##  **Hepatitis B vaccine or titer** every ## years or one series. Date of most recent series: ##/##/##  **PPD** every ## years. Note if PPD is contraindicated: \_\_\_\_\_\_\_\_\_  **Chest X-ray** every ## months/yearly. Note if chest x-ray is contraindicated: \_\_\_\_\_\_\_\_\_  **DTaP series or titer** every ## years or once. Dates of most recent series: ##/##/##  **MMR series or titer** every ## years or once. Dates of most recent series: ##/##/##  **Note any additional immunizations** recommended or me, including frequency and date of most recent or indicate if there are no additional immunizations required. | | |
| **These are the ROUTINE diagnostic procedures and/or screenings recommended for everyone, which I should receive regularly.** | | **Annual Physical** *(including documented weight; height; BMI; Blood Pressure, Pulse, Respirations; personal/family history; past medical history; past surgeries; systems assessment [any deferred assessment must be accompanied by document plan for monitoring or justification for not assessing]; Plan of Care; Health counseling [to individual and caregiver]).*  **Annual Labs** (*including complete blood count; chemistry panel; urinalysis.)* Describe any annual blood work specifically required for me, or indicate if no additional bloodwork is required.  **Vision Exam** *(every 1-2 years as recommended by provider.)*  **Hearing Exam** *(every 1-2 years as recommended by provider.)*  **Dental** and/or oral health exam yearly.  **Dental** cleanings.  **Abnormal Movement Screening (AIMS or DISCUS)** every ## months.  **Neurology** every ## months/years.  **Gastroenterology** every ## months/years.  **Psychiatry** every ## months/years.  **Podiatry** every ## months/years.  **Urology** every ## months/years.  **Dermatology** every ## months/years.  **Other:** Describe any other health screenings/procedures unique to me. | | |
| **These are the diagnostic procedures I should receive regularly due to my GENDER.** | | **Women**  **Annual mammogram** *(If there are deterrents, ultrasound of the breasts, monthly manual breast exam by a qualified health professional, annual manual berast exam by PCP/GYN)*.  **Pelvic** exam/PAP smear  Other: Describe any other health screenings/procedures unique to me.  **Men**  **Prostate** screening after age 40 *(PSA, rectal exam.)*  **Other:** Describe any other health screenings/procedures unique to me. | | |
| **These are diagnostic procedures I should receive regularly after I reach a certain AGE.** | | **Colonoscopy** at age 50, then every 10 years unless results indicate a repeat sooner. Date of most recent Colonoscopy: ##/##/##  **Bone** mineral density exam or DEXA Scan (recommended every ­XX years). Date of most recent density exam or DEXA Scan (indicate which): ##/##/## \_\_\_\_\_\_\_\_\_\_\_  **Other:** Describe any other health screenings and how frequently I should receive them, or indicate if there are none. | | |
| **I may need additional routine oversight and screening due to a diagnosis in these areas** | | These conditions are more commonly seen in individuals with **AUTISM** as a diagnosis, and additional routine medical oversight/screening is recommended:  • Hearing loss • Nasal allergies • Sleep Disorders • Food allergies • GERD • and • Neurological disorders (including seizures, Tourette’s syndrome, motor tics)  These conditions are more commonly seen in individuals with **CEREBRAL PALSY** as a diagnosis, and additional routine medical oversight/screening is recommended:  • Hearing loss • Vision problems • Dysphagia • GERD • Gastroparesis • Seizures • Recurrent urinary tract infections • Respiratory disorders • Sleep disturbance • Muscle spasms • Skeletal and joint disorders  These conditions are more commonly seen in individuals with **DOWN SYNDROME** as a diagnosis, and additional routine medical oversight/screening is recommended:  • Cataracts and other ophthalmological conditions • Hearing loss • Tooth anomalies • Congenital heart defects • Mitral valve prolapse and valvular regurgitation • Obstructive sleep apnea • Dysphagia • Spinal cord compression • Seizures • Dementia • Dermatological disorders • Testicular disorders  These conditions are more commonly seen in individuals with FETAL ALCOHOL **SPECTRUM DISORDER** as a diagnosis, and additional routine medical oversight/screening is recommended:  • Hearing loss • Vision problems • Sleep disturbance • Seizures • Sensory processing disorders  **Other:** These conditions are more commonly seen individuals with **DESCRIBE CONDITION AND DIAGNOSIS** as a diagnosis, and additional routine medical oversight/screening is recommended:  • Describe condition • Describe condition • Describe condition • Describe condition • Describe condition | | |
| **These are the supports I need to be successful with screenings and procedures that are invasive:** | | **Dental**: Describe the types of support needed for me to have a successful dental visit, or indicate if no support is needed.  **Mammogram**: Describe the types of support needed for me to have a successful mammogram, or indicate if no support is needed.  **Gynecology Exam**: Describe the types of support needed for me to have a successful Gynecology visit, or indicate if no support is needed.  **PCP/Specialist**: Describe the types of support needed for me to have a successful visit, or indicate if no support is needed.  **Diagnostic tests** (x-rays, labs, etc.): Describe the types of support needed for me to have a successful completion of diagnostic exams, or indicate if no support is needed.  **Other**: Describe other procedures, and the support I need for success, or indicate if there are none. | | |
| **These are things I rely on supporters to check and document regularly so that I can remain healthy:** | | **Bowel Tracking**: Record my bowel movements on the bowel tracking from each time I have a bowel movement.  **Sleep Tracking**: Record when I am awake or asleep on the sleep data form.  **Blood Pressure**: Record my BP on the BP log each time it is measured.  **Blood Glucose**: Record my blood sugar each time it is obtained with the glucometer on the blood glucose tracking form.  **Fluid Intake**: Measure and record my fluid intake on the enter name of form each time I consume any fluids.  **Meal Intake**: Record amounts of solid foods I consume on the enter name of form each time I eat. Refer to Intake/Output healthcare plan for details.  **Output**: Record my urine output on the enter name of form each time I void.  **Seizures**: Record all of my seizures on the seizure log.  **Oral Hygeine**: Record each time I perform oral hygiene.  **Skin**: Observe skin during care and record and report any concerns.  **Other:** Describe any other things that supporters check daily or more often, or indicate if there are none. | | |
| **Documentation:** | | Describe the things that supporters should write down and where they should write them down. | | |
| **Nursing Intervention:** | | Describe those things that must be done by the nurse relative to routine and preventative services, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. | | |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

RN Typed Name and Agency

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