**Healthcare Plan for Risk of Urinary Tract Infection**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my medical diagnoses and conditions related to my risk of urinary tract infection:** | List all diagnoses or conditions that increase my risk of urinary tract infection. |
| **I am allergic or sensitive to these things:** | List all known allergies and sensitivities. |
| **The goal of this Healthcare Plan is:** | [ ]  I will not experience any urinary tract infections for the duration of the ISP year.[ ]  I will increase my fluid consumption to ### ounces/day.[ ]  Describe any other goal for management of my risk of UTI here.  |
| **Progress in the past year:** | Describe the status of my health for the past year related to risk of urinary tract infection. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 have blood in my urine and am experiencing fever above ###** °.**🡪 have a rapid pulse and/or shortness of breath.****🡪 seem confused or disoriented.****🡪 seem to be in extreme pain.****🡪 lose consciousness (become unresponsive).****🡪 Describe any additional instructions here.** |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **Over the past year, I have had urinary tract infections:** | [ ]  More than once a month | [ ]  Less than once a month, but several times a year | [ ]  One to three times in the past year | [ ]  It has been over a year since my last UTI |
| **These are the things that increase my risk of urinary tract infections:** | [ ]  I am over 65 years of age.[ ]  I have gone through menopause.[ ]  I am incontinent of bladder and/or bowel.[ ]  I have difficulty with proper hygiene when going to the bathroom.[ ]  I have a condition that affects my muscles (such as cerebral palsy).[ ]  I have a condition that impacts my immune system (such as diabetes, cancer, HIV).[ ]  I have difficulty drinking enough fluids.[ ]  I use a catheter for voiding urine.[ ]  **Other:** Describe any other conditions or circumstances that increase my risk for urinary tract infection or indicate if there are none. |
| **These are the things supporters can do with and for me to help avoid developing urinary tract infections:** | [ ]  Make sure I practice appropriate hygiene skills when I use the bathroom.[ ]  If I am incontinent, check my briefs regularly, and help me change whenever I am wet or soiled.[ ]  Help me wash my hands frequently.[ ]  Help me drink enough fluids during the day. (Ask my doctor for guidance on how much I should be drinking.)[ ]  Help me follow my diet order, including providing alternate choices for foods and beverages my doctor says are not good for me.[ ]  If I rely on a catheter, make sure any procedures associated with this are completed in a sterile environment.[ ]  When I have been diagnosed with a urinary tract infection, make sure I finish the medicine my doctor prescribes for me.[ ]  **Other:** Describe any other interventions I should take to avoid urinary tract infections, or indicate if there are none. |
| **These are signs that I might have a urinary tract infection and I should see my doctor:** | [ ]  I have difficulty urinating or I am urinating more frequently than usual. [ ]  I have dark or cloudy urine. (Urine should be clear and light colored.) [ ]  My urine has a strong or foul odor. [ ]  I have pain in my lower abdomen or lower back. [ ]  I let you know that I feel a burning sensation when I urinate. [ ]  I have blood in my urine or my urine appears pink. [ ]  I am incontinent, and this is unusual for me. [ ]  I have nausea, with or without vomiting. [ ]  I have a fever. [ ]  **Other**: Describe any other signs that I might have developed a urinary tract infection, or indicate if there are none. |
| **Documentation:**  | Describe the things 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 my risk of urinary tract infection, 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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