**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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