Care Plan

Patient's Name.....
Age/Sex.....

Reg. No .....Body Wt.....…

Patient's Name		Age	_____Yr.	Sex	M □ F□
Reg. No.		Body Wt.			
Arrival Time		Assessment Time			
Type	□Walk in □Referred by Dr . ..... to Dr. ..... □Referred by Relatives/Friends ..... to Dr. ..... □Follow up case of Dr.				
Previous Admission	No Yes	MLC No.			
Presenting Complaints:					

Primary Assessment:

Assessment Circulation	˚□Pulse ……/min □BP……/……mm Hg □ Heart Rate ……./min □Peripheral Pulses □Temp..... F	Assessment Airway	□Patent □Protected □Maintainable □Compromised	Assessment Breathing	RR:..... /min □Laboured IX!SpO_2…….% on Room Air □SpO2.....% on O2

Glasgow Coma Scale :

Response	1	2	3	4	5	6
Eye Opening	None	To pressure	To speech	Spontaneous	---	---
Verbal	None	Sounds	Words	Confused	Oriented	---
Motor	None	Extension	Abnormal Flexion	Normal Flexion	Localizing	Obeying Commands

□Cardiac Monitor: □GRBS: ..... mg/Dl AVPU Pupils: NSERTL/	Pain Score: □ No Pain □ Mild Pain □ Moderate Pain □ Severe Pain

Systemic Assessment:

ROS	HEENT: CHEST: CVS: ABD: EXT: Neuro: Others:
Ample History	Allergies: Medication: Past History: Last Meal: Events Prior to the incident:
Work Diagnosis/DD	

Investigations:

POC Tests	POC Tests	Blood	Urine	X-Rays	USG	CT Scan/MRI	Other s

Treatment Advised:

Drug	Dose	Route	Advised By	Time
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		

Procedures:

Name	Done By	Notes

Referral/ Consultations:

Specialty	Physician	Opinion
Problems/ Diagnosis		
Shifted to	ICU HD U Ward Discharged to Home Lama to:	
Admitting Consultant		

Re-Assessment

Vitals	**P**……..., **BP**…… **RR ……., SpO$_2$ …….. Temp…….**
Notes:	

Vitals at the Time of Transfer	P	BP	RR	SpO$_2$	Temp

Notes:

Doctor's Name …….. Signature

…….. Patient / Patient Attendant Name : ……..

Signature

……

Discharge Planning

Social Support needed at home	□ Yes □ No If Yes, Details:
Home equipment anticipated	□Yes □ No If Yes, Details:
Physiotherapy anticipated at home	□Yes □ N o If Yes, Details:
Wound care needs to be anticipated at home	□Yes □ N o If Yes, Details:
Dressing every third day	□Yes □ N o If Yes, Details:
Strict diabetic diet	□Yes □ N o If Yes, Details:

Psychological Assessment	Psychological Referral Needed	Yes No
Functional Needs	Physiotherapy Referral	Yes No
Nutritional Needs	Dietary Referral	Yes No
Restraint if applicable	Physical/Chemical	Yes No
Any other referral		
Family Education		
Investigation Advised	Treatment Advised	Expected Outcome/ Measurable Goals

Declaration by the Patient/Relative/Attendant I hereby declare that the facts recorded above regarding my history are based on my narration and are accurate to the best of my knowledge	Name: Relationship with Patient Date: Time:

Remarks of consultant:

Expected Outcome at Discharge:

Vitals Stable Ambulatory- Yes/No

Others Blood Sugar Levels - Controlled

Surgical wound -Clean 1.

Pain Score Below 4 Diet-Normal/Supplemental 2.

3.

Name of Resident: Emo Id.: Date & Time: Signature:	Counter Sign by consultant in charge Name of Resident: Date & Time: Signature:

CARE PLAN

STATUS AT THE BEGINNING OF THE TREATMENT/INCLUDING IDENTIFICATION OF PATIENT SPECIAL NEEDS	
DIAGNOSIS (PROVISIONAL/DIFFERENTIAL)	
GOAL/DESIRED OUTCOME	
TREATMENT PLAN/INTERVENTIONS (Conservative/Surgical)	PREVENTIVE CARE
ANTICIPATED COMPLICATIONS WITH PROGNOSIS	
Consultant's Name & Signature Date/Time	Patient's/Attendant's Signature

REVISED CARE PLAN

POST INITIAL TREATMENT STATUS INCLUDING PATIENT SPECIAL NEEDS	
ADDITIONAL DIAGNOSIS	
GOAL/DESIRED OUTCOME	

REVISED TREATMENT PLAN (Conservative/Surgical & Referral, if any)	PREVENTIVE CARE
ANTICIPATED COMPLICATIONS WITH PROGNOSIS	
Consultant's Name & Signature Date/Time	Patient's/Attendant's Signature

Disclaimer

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