Care Plan

Name: _____ DOB _____ Date of Enrolment _____ Effective Date _____

Diagnosis _____

Md recommendations _____ Per MD _____ Per Client _____

Diet _____

Nursing Needs _____

Social/Recriational Activities _____

Concerns/Problems	Goals	Aproach/Action

Care plan must also list current medications (MD notes whether self-administered or not), MD recommendations, assistance, prescribed social and recreational activities, and any other patient-specific needs.

RN/LPN Name, Signature, Date: _____

Administrator: _____