Patient's Initials:_____

Age: ____ Dr.: _____

Room No.: _____Current Medical Diagnosis:

_____

_____

PATIENT CARE PLAN

Student: _____

Date: _____

Pt Allergies: _____

_____

Surgery (Type & Date): _____

_____

Activity: _____

Diet: _____

Other: _____

ASSESSMENTS	NURSING DIAGNOSIS	PATIENT GOALS	NURSING INTERVENTIONS	EVALUATION