1 Patient Information

1 PATIENT DETAILS

Name:		Date of Care Plan:	
DOB:		Unit / Room:	
Age / Sex:		MRN:	
Nurse / Provider:		Primary Diagnosis:	
Reason for Nursing Care Plan:			

CS Clinical Summary

2 CLINICAL OVERVIEW

Brief overview of current condition — primary diagnosis, relevant comorbidities, clinical status, functional limitations, safety concerns, and reason nursing care planning is required...

AD Assessment Data

3 SUBJECTIVE & OBJECTIVE FINDINGS

3a SUBJECTIVE DATA

Patient-reported symptoms, concerns, pain, fatigue, dyspnea, weakness, anxiety, nausea, functional limitations, or caregiver-reported concerns...

3b OBJECTIVE DATA

Vital signs, physical exam findings, lab/imaging results, intake/output, mobility status, wound findings, O2 needs, pain score, mental status, fall risk, skin integrity, and other measurable indicators...

ND Nursing Diagnosis

4 NURSING PROBLEM STATEMENT

Nursing diagnosis using clinically appropriate terminology. Actual or risk-based nursing problems. Examples: Acute Pain related to tissue injury as evidenced by patient report. Impaired Gas Exchange related to respiratory compromise. Risk for Falls related to weakness or altered mental status. Impaired Skin Integrity related to immobility. Deficient Knowledge related to new diagnosis or treatment plan...

GO Goals / Expected Outcomes

5 PATIENT-CENTERED GOALS

5a SHORT-TERM GOALS

Expected outcomes achievable during current shift, visit, or immediate care period...

5b LONG-TERM GOALS

Outcomes related to recovery, discharge readiness, functional improvement, symptom control, or prevention of complications...

CP NCP 4-Column Care Plan

6 CARE PLAN STRUCTURE

Nursing Diagnosis / Problem	Goals / Expected Outcomes	Nursing Interventions	Rationale / Evaluation
Problem 1			
Problem 2			
Problem 3			

IN Interventions

7 NURSING INTERVENTIONS

Monitoring frequency and parameters, medication administration, safety precautions, skin/wound/repositioning care, mobility assistance, respiratory support, nutrition/hydration/elimination support, patient/caregiver education, escalation criteria...

RT Rationale

8 CLINICAL REASONING

Clinical reasoning behind each intervention — link to patient needs, risk reduction, symptom control, complication prevention, or functional improvement...

EV Evaluation

9 PATIENT RESPONSE & GOAL PROGRESS

Goal Status (met / partially met / not met): _____

Objective changes in symptoms or clinical status: _____

Patient tolerance of interventions: _____

Ongoing barriers: _____

Need for care plan revision: _____

PU Plan / Care Plan Updates

10 PLAN UPDATES

Continue, modify, or discontinue care plan. Changes to goals, interventions, monitoring, or escalation plan based on patient response...

FU Follow-Up / Reassessment

11 REASSESSMENT PLAN

Reassessment timeframe: _____

Pain, vital signs, mobility, respiratory status, wound status, fall risk, skin integrity, intake/output, or response to education...

NURSE / PROVIDER NAME	CREDENTIALS	DATE	TIME