Dysphagia Care Plan

PATIENT INFORMATION

Name: _____ Age: _____

Gender: _____

Medical History:

ASSESSMENT

Subjective:

Objective:

NURSING DIAGNOSIS

Specify below:

GOALS AND OUTCOMES

Long-term:

Short-term:

NURSING INTERVENTIONS

Specify below:

RATIONALE

Specify below:

EVALUATION

Specify below:

ADDITIONAL NOTES

Specify below:

NURSE INFORMATION

Name: _____ License number: _____

Contact number: _____