

Fluid Volume Deficit Nursing Care Plan

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Patient ID: _____

Contact Number: _____ Email Address: _____

Indicate the following:

- ☐ Vomiting
- ☐ Diarrhea
- ☐ Excessive sweating
- ☐ Fever
- ☐ Frequent urination
- ☐ Lack of oral fluid

Current medications:

Pregnancy or breastfeeding:

ASSESSMENT

Perform a comprehensive head-to-toe evaluation - Rationale

Perform a comprehensive head-to-toe evaluation - Notes/Referral

Monitor vital signs - Rationale

Monitor vital signs - Notes/Referral

Review laboratory findings - Rationale

Review laboratory findings - Notes/Referral

Assess skin elasticity - Rationale

Assess skin elasticity - Notes/Referral

Examine urine color and concentration - Rationale

Examine urine color and concentration - Notes/Referral

Listen to cardiac sounds - Rationale

Listen to cardiac sounds - Notes/Referral

Evaluate cardiac rhythm - Rationale

Evaluate cardiac rhythm - Notes/Referral

Evaluate mental status - Rationale

Evaluate mental status - Notes/Referral

INTERVENTION

Encourage or prompt the patient regarding oral fluid intake - Rationale

Encourage or prompt the patient regarding oral fluid intake - Notes/Referral

Provide intravenous hydration if necessary - Rationale

Provide intravenous hydration if necessary - Notes/Referral

Educate the patient and family on potential causes of dehydration - Rationale

Educate the patient and family on potential causes of dehydration - Notes/Referral

Instruct the patient and family on monitoring fluid intake and output - Rationale

Instruct the patient and family on monitoring fluid intake and output - Notes/Referral

Conduct daily patient weight assessments - Rationale

Conduct daily patient weight assessments - Notes/Referral

Educate the patient on the significance of maintaining proper hydration and nutrition consistently - Rationale

Educate the patient on the significance of maintaining proper hydration and nutrition consistently - Notes/Referral

Physician's Notes and Recommendations

Physician's Signature

Date: _____ dd / mm / yyyy