Stroke Nursing Care Plan

PATIENT INFORMATION

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

Gender: _____ Patient ID: _____

Contact Number: _____ Email Address: _____

ASSESSMENT

Risk Factors

- [ ] HTN
- [ ] Diabetes
- [ ] Smoking
- [ ] High risk age group
- [ ] High risk family medical history

Expected Findings

- [ ] Cerebral edema
- [ ] Headache
- [ ] Motor deficits
- [ ] Aphasia

Laboratory Results

- [ ] Troponin I
- [ ] Creatine Kinase-MB
- [ ] Coagulation studies: PT, PTT
- [ ] Lipid profile

Diagnostic Procedures

- [ ] CT Scan
- [ ] MRI
- [ ] ECG

Immediate Safety Considerations

- [ ] Impaired gag reflex
- [ ] Impaired mobility
- [ ] Impaired swallowing and speech
- [ ] Spatial perceptual problems

Diagnosis / Assessment

Intervention

Rationale

Referral / Review date: _____ dd / mm / yyyy

Physician's Notes and Recommendations

Physician's Signature

Date: _____ dd / mm / yyyy