



45 Day Review – Day Program

Person Served: _____ Date: _____

Location: _____ Nurse: _____

OVERVIEW

Sleep: _____ Appetite: _____ Bowels: _____
Urine: _____ Seizures: _____ Ambulation: _____
Skin: _____ A&O: _____
Physical Changes: _____

Medication Changes: _____

TD Screen: _____
Diet: _____
Allergies: NKDA Other: _____

COMMENTS

Temp: _____ Pulse: _____ Blood Pressure: _____
Resp: _____ Heart: _____ Lungs: _____
ABD / BS: _____
Weight:

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

MEDICATION REVIEW

Care Plan reviewed (Initiated); continue present care and goals.

At the time of this evaluation, the above mentioned Person Served health care needs appear to be chronic, stable, uncomplicated, routine, predictable, and the environment is conducive to delegation of nursing tasks.

Nursing Services Provided by **Dimensional Health Care Associates, Inc.**

Phone (410) 654-1010 ▪ Fax (410) 654-1049 ▪ www.dhcamd.com