

Nursing Oversight and Care Management Nursing Care Plan

***Note: please use the second page for any information that does not fit into the columns on the first page. Use extra pages as necessary**

Name: _____ Date of Birth: _____

NOCM Nurse: _____ Care Coordinator: _____

Primary Physician: _____ Primary Med. Dx: _____

Medications: _____

Equipment/technology/assistive devices: _____

Diet/activities/other: _____

	0	1	2	3	4	5
Level of Self Care Key	Completely Independent	Requires Use of Assistive Device	Needs Minimal Help	Needs Assistance and/or Some Supervision	Needs Total Supervision	Needs Total Assistance or Unable to Assist

NURSING DIAGNOSIS	GOAL	INTERVENTIONS	EVALUATION/OUTCOME
		<i>Level of Self Care:</i> ____	
		<i>Level of Self Care:</i> ____	
		<i>Level of Self Care:</i> ____	
		<i>Level of Self Care:</i> ____	
		<i>Level of Self Care:</i> ____	

Date

Signature

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Additional Information/Comments: