**Nursing Care Plan for Fever**

### **Patient Information**

* **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Gender:\_\_\_\_\_\_\_\_\_\_\_\_**
* **Patient ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Medical History**

* **Primary Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Fever Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Assessment**

* **Vital Signs:**
  + **Temperature:\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Pulse:\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Respiration:\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Blood Pressure:\_\_\_\_\_\_\_\_\_\_\_\_**
* **Symptoms:**
  + **Chills: ☐ Yes ☐ No**
  + **Sweating: ☐ Yes ☐ No**
  + **Headache: ☐ Yes ☐ No**

### **Nursing Diagnoses**

1. **Nursing Diagnosis: Hyperthermia**
   * **Related to: Infection**
   * **As evidenced by: Elevated temperature, sweating, chills**

### **Goals and Expected Outcomes**

* **Short-term Goals:**
  1. **Reduce fever within 24 hours.**
  2. **Maintain hydration levels.**
* **Long-term Goals:**
  1. **Prevent recurrence of fever.**
  2. **Educate patients on fever management.**

### **Nursing Interventions**

1. **Intervention: Monitor Vital Signs**
   * **Rationale: Track fever progression**
   * **Frequency: Every 4 hours**
2. **Intervention: Administer Antipyretics**
   * **Rationale: Reduce fever**
   * **Frequency: As prescribed**

### **Evaluation**

* **Goal #1 Met/Not Met: ☐ Met ☐ Not Met**
  + **Evidence: Temperature reduced to normal range**
* **Goal #2 Met/Not Met: ☐ Met ☐ Not Met**
  + **Evidence: Patient maintains hydration**