# Restrictive Health Care Plan

Client Name:_____ DOB:_____

Date of Assessment: _____ Referring Agency _____

Name and license number of licensed professional making this assessment:

_____ _____

Name and Telephone Number(s) of emergency medical contact: _____

_____

Medical Condition of the client (diagnosis and simple description): _____

_____

_____

_____

_____

Client's medical condition is temporary: Yes☐ No☐

Client's medical condition is chronic but stable: Yes☐ No☐

Client requires 24-hour nursing care: Yes☐ No☐

Any procedures that the client he/she needs while in the program: _____

_____

_____

_____

_____

Describe the client's ability to perform the procedure: _____

_____

_____

_____

_____

Alternative Plan when the client cannot perform self-care: [who will be responsible for the medical care of the client] _____

_____

_____

_____