

# Stroke Nursing Care Plan

## Patient Information:

Full Name:

Date of Birth:

Gender:

Patient ID:

Contact Number:

Email Address:

## Assessment

<b>Risk Factors</b>	<input type="checkbox"/> HTN <input type="checkbox"/> Diabetes <input type="checkbox"/> Smoking <input type="checkbox"/> High risk age group <input type="checkbox"/> High risk family medical history	
<b>Expected Findings</b>	<input type="checkbox"/> Cerebral edema <input type="checkbox"/> Headache <input type="checkbox"/> Motor deficits <input type="checkbox"/> Aphasia	
<b>Laboratory Results</b>	<input type="checkbox"/> Troponin I <input type="checkbox"/> Creatine <input type="checkbox"/> Kinase-MB <input type="checkbox"/> Coagulation studies: PT, PTT, Lipid profile	

<b>Diagnostic Procedures</b>	<input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> ECG	
<b>Immediate Safety Considerations</b>	<input type="checkbox"/> Impaired gag reflex <input type="checkbox"/> Impaired mobility <input type="checkbox"/> Impaired swallowing and speech <input type="checkbox"/> Spatial perceptual problems	

<b>Diagnosis / Assessment</b>	<b>Intervention</b>	<b>Rationale</b>	<b>Referral / Review date</b>

<b>Physician's Notes and Recommendations</b>

<b>Physician's Signature:</b>
Date: