RESTRICTED HEALTH CONDITION CARE PLAN

Consumer:
UCI#:
DOB:
RHCCP training Date:
Date to be reviewed:

Persons Participating in Development of Plan: (*please list below*)

Consumer or authorized representative:
Primary physician:
Placement agency representative:

Primary Physician
Name, phone number and emergency contact

Physician statement: (consumer name) has a medical condition that requires procedures on an ongoing basis. The condition is stable. (consumer name) is unable to perform these procedures him/herself. (consumer name) does not require 24 nursing care and/or monitoring. This plan needs to be reviewed annually (see date above). This plan meets the medical scope of practice requirements.

____ (MD signature)

Restricted Health Condition
State what the condition is, what services or procedures are required, client's ability to do it him/herself.

Personnel performing procedures *(if client unable to do him/herself)*

Objective(s) *e.g., Johnny's diabetes will be monitored, by himself, or CP*
1.

Plans (s):