Nursing care plan template, blank

Free template from soapnotes.xyz. Fill it in by hand or type over it.

PATIENT DETAILS

Patient

Date and time started

Unit and setting

Admitting reason or medical diagnosis

Allergies

Nurse

ASSESSMENT DATA

Subjective data (what the patient says, in their words):

Objective data (vital signs, observations, measurements, results):

Relevant history and current treatment:

Patient's priorities and goals:

Safety risks (falls, skin, infection, swallowing, other):

NURSING DIAGNOSIS 1

Problem (the label you are using)

Related to (cause or contributing factor):

As evidenced by (the signs and symptoms you found):

Priority

GOAL AND EXPECTED OUTCOME 1

Goal (what should change):

Measurable outcome, with a time frame:

Target date and time:

NURSING INTERVENTIONS 1

Intervention (what you will do, how often, who does it):

Rationale (why this helps):

Patient and family teaching:

Referrals or orders needed:

EVALUATION 1

Date and time evaluated:

Evidence (what you observed or measured):

Outcome: [ ] met [ ] partly met [ ] not met

Next step: [ ] continue [ ] revise [ ] resolve

NURSING DIAGNOSIS 2

Problem:

Related to:

As evidenced by:

Priority:

GOAL AND EXPECTED OUTCOME 2

Goal:

Measurable outcome, with a time frame:

NURSING INTERVENTIONS 2

Intervention:

Rationale:

Teaching:

EVALUATION 2

Date and time evaluated:

Evidence:

Outcome: [ ] met [ ] partly met [ ] not met

Next step: [ ] continue [ ] revise [ ] resolve

DISCHARGE AND CONTINUING CARE

Needs after discharge (equipment, home support, follow-up):

Care plan reviewed with patient: [ ] yes Date:

Signature and credentials:

Educational template, not medical or legal advice. Follow your employer and regulator rules.