



INTERDISCIPLINARY PLAN OF CARE

| | |
|--|-------------------------------|
| <p>Date: _____ Treatment Plan: _____ _____</p> <p>Diagnostic Plan: _____ _____</p> <p>Goals: _____ _____</p> <p>Disciplines Involved (check all appropriate boxes): <input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Social Worker <input type="checkbox"/> Dietitian <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Utilization Review <input type="checkbox"/> Other _____</p> <p>_____</p> | |
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