Impaired Physical Mobility Nursing Care Plan

IMPAIRED PHYSICAL MOBILITY NURSING CARE PLAN

Details:

[ClientInfo]

Specify below:

Specify below:

1. Test/s:

Result/s:

2. Test/s:

Result/s:

3. Test/s:

Result/s:

4. Test/s:

Result/s:

5. Test/s:

Result/s:

Specify below:

1. Long-term:

Short-term:

2. Long-term:

Short-term:

3. Long-term:

Short-term:

4. Long-term:

Short-term:

1. Nursing interventions:

Rationale:

2. Nursing interventions:

Rationale:

3. Nursing interventions:

Rationale:

4. Nursing interventions:

Rationale:

5. Nursing interventions:

Rationale:

Specify below:

Specify below:

Name: _____ License number: _____

Contact number: _____