

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
INFIRMARY HEALTH CARE PLAN**

Inmate Name		DOC No.	Age	Gender
Physician		Facility	Diagnosis	
Short Range Goals:				
Long Range Goals:				
Date	Problem	Approach		
Discharge Plan: _____ _____ _____				
Date	Medications	Date	Treatments	
ACTIVITIES	PHYSICAL TRAITS	LAB PROCEDURES	X-RAY PROCEDURES	OTHER
<input type="checkbox"/> Bed Rest <input type="checkbox"/> Dangle <input type="checkbox"/> Chair <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Up ad. lib	<input type="checkbox"/> Paraplegic <input type="checkbox"/> Hemiplegic <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Other (specify): _____			
BOWEL/BLADDER	PROSTHESIS	HYGIENE	ISOLATION (SPECIFY)	RESTRAINTS
<input type="checkbox"/> Colostomy <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter <input type="checkbox"/> Commode(BSC) <input type="checkbox"/> Bathroom <input type="checkbox"/> Catheter Care	<input type="checkbox"/> Dentures <input type="checkbox"/> Contact(s) <input type="checkbox"/> Glasses <input type="checkbox"/> Eye <input type="checkbox"/> Limb <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Bed Bath <input type="checkbox"/> Partial Bath <input type="checkbox"/> Self Bath <input type="checkbox"/> Assist Bath <input type="checkbox"/> Tub <input type="checkbox"/> Shower	<input type="checkbox"/> Respiratory <input type="checkbox"/> Wound <input type="checkbox"/> Contact	<input type="checkbox"/> Siderails <input type="checkbox"/> Posey <input type="checkbox"/> Soft Wrist <input type="checkbox"/> Other