

Health Promotion Activities Plan

****This sample is to assist you in developing a health promotion activity plan. It is not intended to replace medical advice. Any instructions given by the physician regarding this diagnosis must be included.**

Name of Individual:

Health Concern/Issue * (Diagnosis)	FIBROIDS (UTERINE)	
Related Body System	Vision Respiratory Lymphatic Dental Hearing Digestive Integumentary (Skin) Endocrine Cardiovascular Nervous Musculoskeletal Genitourinary Blood	
What is it? (Provide definition)	Uterine fibroids are benign (not malignant, not progressive) tumors of muscle and connective tissue that develop within, or are attached to, the uterine wall.	
Signs and Symptoms (general)	Sensation of fullness or pressure in lower abdomen, pelvic cramping or pain with periods, abdominal fullness and gas, increase in urinary frequency, heavy menstrual bleeding-sometimes with the passage of blood clots, may have sudden-severe pain depending on fibroid. THERE ARE OFTEN NO SYMPTOMS.	
Signs and Symptoms (specific to the person)		
Promotion/strategy support required * List very specific steps that the individual and/or caregivers use to support the person's health condition. Include information about monitoring health status. Who is called for changes/ problems in this person's health condition? What is tracked, where it can be found, and who follows up on documentation required for this health condition? Who provides what training for the person and staff about the health condition and when?	<ul style="list-style-type: none"> ➤ Watch <u>(name of person)</u> for signs and symptoms listed above and report to <u>(title of person in agency who is responsible to receive this information)</u>. ➤ Give medication as ordered (see Medication Administration Record/Log). If a prn (as needed) medication is given, the result must be documented per agency policy. ➤ <u>Include any specific instructions regarding this diagnosis from the treating physician.</u> ➤ Documentation about this condition can be found in the medical record under <u>(list section here)</u>. ➤ Receive training regarding this diagnosis and plan of care (include when to notify the physician) by <u>(title of person who provides medical training)</u> at least <u>(indicate frequency of training)</u> or as changes occur. This should be documented for all staff in the home. 	
Frequency of support *	<i>Fill in what physician (e.g. primary care physician, gynecologist) treats this condition and how often the person is seen.</i>	
Desired outcome *	To recognize symptoms as soon as possible to relieve pain or obtain treatment.	
Person/agency responsible *	<u>(Name of person)</u> , caregivers, agency nurse, primary care physician, <u>(specialist, if applicable)</u> <i>(The responsible parties may vary according to your agency; please place specific roles in this section. Some other examples might be health care coordinator, program specialist, house manager.)</i>	

* FIELDS FOUND IN THE HEALTH PROMOTION SECTION OF THE ISP