**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:

### CEREBRAL VASCULAR ACCIDENT (STROKE) – *This plan is for someone who has had a stroke. Sudden signs such as dropping, vision changes, inability to walk or talk, facial droop, or weakness on one side of the body may be signs of a stroke in progress and would need immediate attention – call 911*

### Related Body System

<table>
<thead>
<tr>
<th>Vision</th>
<th>Respiratory</th>
<th>Lymphatic</th>
<th>Dental</th>
<th>Hearing</th>
<th>Digestive</th>
<th>Integumentary (Skin)</th>
<th>Endocrine</th>
<th>Cardiovascular</th>
<th>Nervous</th>
<th>Musculoskeletal</th>
<th>Genitourinary</th>
<th>Blood</th>
</tr>
</thead>
</table>

### What is it? *(Provide definition)*

Disruption of the blood supply to a part of the brain resulting in tissue death in that area of the brain and corresponding neurological deficits

### Signs and Symptoms *(general)*

Symptoms are dependent on the area of the brain affected, but may include weakness, paralysis, memory loss, dysphagia (difficulty swallowing), difficulty speaking clearly, depression; symptoms usually occur on one side of the body

### Signs and Symptoms *(specific to the person)*

- Watch *(name of person)* for signs and symptoms listed above and report immediately to *(title of person in agency who is responsible to receive this information).*
- 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.
- Ensure that *(name of person)* receives diet recommended by physician *(list diet here).*
- *(include any specific instructions regarding this diagnosis from the treating physician).* For example, stop smoking, weight loss plan, exercise plan, therapies (occupational, speech, physical)
- Documentation about this condition can be found in the medical record under *(list section here).*
- Receive training regarding this diagnosis and plan of care (include when to notify the physician) by *(title of person who provides medical training)* at least *(indicate frequency of training)* or as changes occur. This should be documented for all staff in the home.

### Frequency of support *

*Fill in what physician (e.g. primary care physician, cardiologist, vascular specialist) treats this condition and how often the person is seen.*

### Desired outcome *

To recognize symptoms as soon as possible to obtain treatment

### Person/agency responsible *

*(Name of person), caregivers, agency nurse, primary care physician, *(specialist, if applicable)* *(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.)*

* FIELDS FOUND IN THE HEALTH PROMOTION SECTION OF THE ISP