LeadingAge Illinois & Iowa

Restorative Nursing Program Plan

Resident: _____ **Effective Date:** _____ **Room Number/Unit:** _____

Indicate Program:

__PROM __AROM/AAROM __ Splint/Brace __Bed Mobility __Transfer __Walking

__Dressing/Grooming __Eating/Swallowing __Amputation/Prosthesis __Communication

Individualized Goal:

_____

Exercises (including exercise, repetitions, frequency):

1. _____
2. _____

_____

Indicate Program:

__PROM __AROM/AAROM __ Splint/Brace __Bed Mobility __Transfer __Walking

__Dressing/Grooming __Eating/Swallowing __Amputation/Prosthesis __Communication

Individualized Goal:

_____

Exercises (including exercise, repetitions, frequency):

1. _____
2. _____

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Indicate Program:

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Individualized Goal:

_____

Exercises (including exercise, repetitions, frequency):

1. _____
2. _____