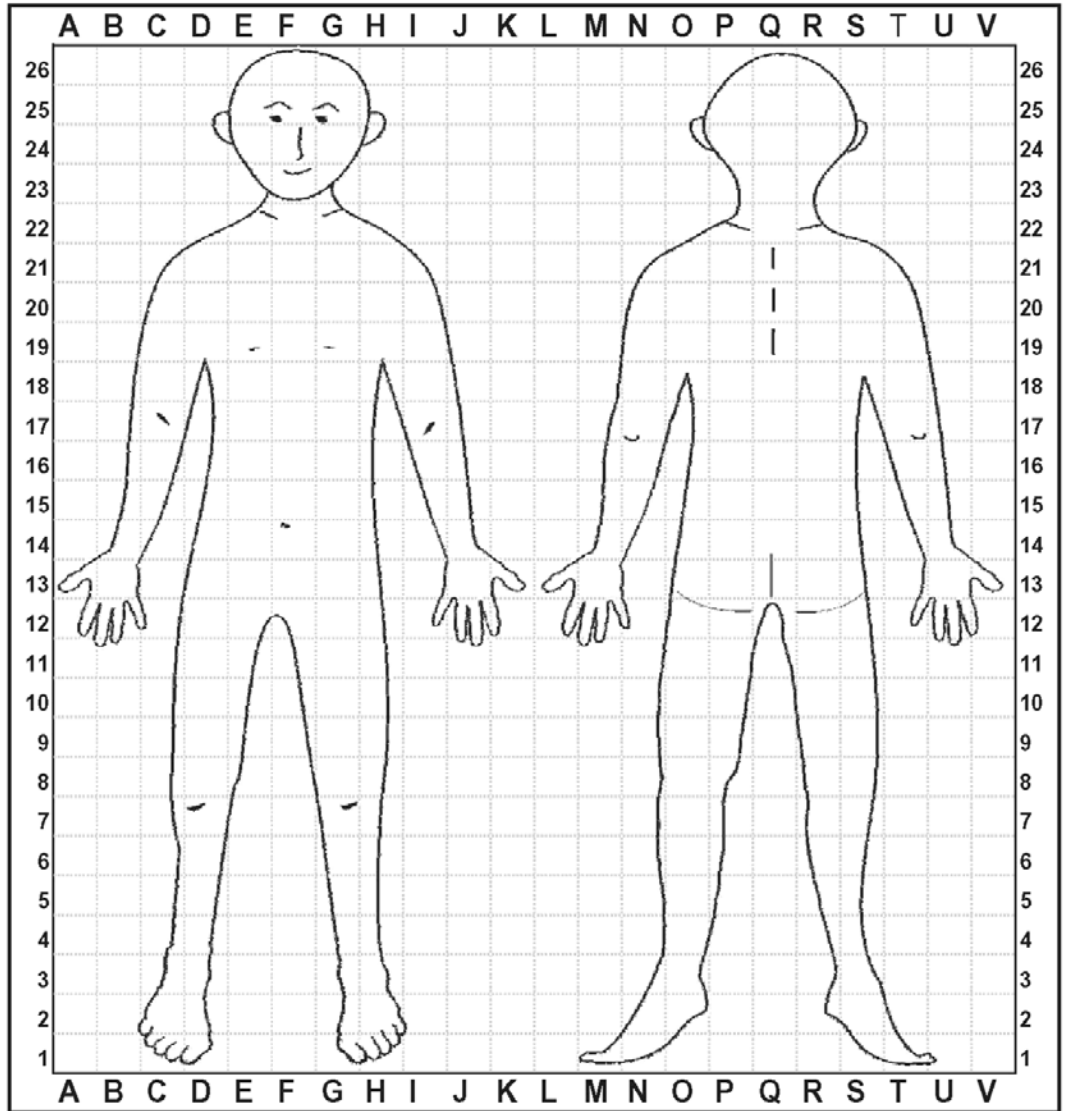
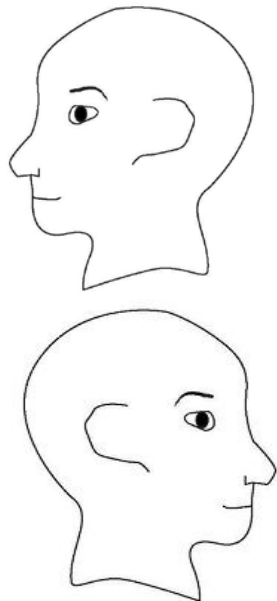


History / Diagnosis \_\_\_\_\_

Symptoms / Concerns \_\_\_\_\_

No Concerns



Goal: \_\_\_\_\_

Plan of Care:  Routine skin care     Interventions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Resident name	First	M.I.	Last	Signature	Date	Time