FORM NO. 1

UNITED REPUBLIC OF TANZANIA MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN   ARUSHA CITY HOSPITAL P.O.BOX 3013 ARUSHA ……	**NURSING CARE PLAN** Hospital Reg. Number…… Surname…… First Name…… Middle Name …… Age…… Sex…….M / F Ward/Unit……Phone no……..

Date of Admission (Date…….. Month…… Year……..) **Medical Diagnosis……**

Patient's problems; i. objective data……ii.subjective data ……

Date	Time	Nursing Diagnosis	Expected outcome	Implementation/Interventions	Evaluation	Provider's Name

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