

Atrial Fibrillation Nursing Care Plan

Patient information		
Patient name:		Age:
Gender:	Date of birth:	
Medical history:		
Assessment		
Subjective	Objective	
	Test/s	Result/s
Nursing diagnosis		
Goals and outcomes		
Long-term	Short-term	

Nursing interventions**Rationale****Evaluation****Additional notes****Nurse's information**

Name:

License number:

Contact number: