

Symptom Management Plan

Patient Name _____

Date of Birth _____ Weight _____

Address _____

Parents' Names _____

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|---|
| <p>Diagnosis</p> |
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| <p>IMPORTANT MANAGEMENT POINTS</p> |
|---|

| Symptom | Current Management | If not controlled |
|---------|--------------------|-------------------|
| | | |
| | | |
| | | |

Written by _____ Checked with _____ Date _____