

**YOUR HOSPITAL  
DEPARTMENTAL SCOPE OF CARE**

Department: \_\_\_\_\_

Review/Revision Date: \_\_\_\_\_ 19

**THE SCOPE OF CARE FOR THIS DEPARTMENT INCLUDES THE FOLLOWING:**

<b>Types of Patients Served (consider major age or disability group)</b>	
<b>Range of Conditions and Diagnoses Treated</b>	
<b>Range of Treatments or Activities Performed (e.g., procedures performed, medications frequently used, as well as activities other than direct patient care)</b>	
<b>Types of Staff Carrying Out these Activities (e.g., Physician, Nurse, Technician, etc.)</b>	
<b>Sites where Care and Service are Provided (e.g., Inpatient or Outpatient Settings, Department, Nursing Unit, etc.)</b>	
<b>Times When Care and Service are Provided (e.g., Shifts, Weekdays, 24 Hour Service)</b>	