



Personal Information:

Patient's Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____

Financial Information:

SS #: _____ Medicare #: _____
MA#: _____ Disability #: _____

Additional Insurance Names and Numbers (all that apply i.e., Medica, Ucare, etc.):

Brief Physical History:

Contact:

Primary Contact Person:

Name: _____

Phone Number(s): _____

Physician/Hospital:

Primary Doctor: _____ Phone Number: _____

Fax Number: _____

Hospital Preference: _____

The information contained in this form is confidential and may be legally privileged. It is intended only for the use of the intended recipients.

Providence Place 3720 23rd Avenue South, Minneapolis, MN 55407
Admission Phone #: 612-968-1361 Fax #: 612-724-9884

...Because the journey matters.

Resident: _____ Physician: _____ MR#: _____

Admission Orders (continued)

May have Two-Step Mantoux Yes No Chest X-ray if Positive History/Results

Activity Level: Up as Tolerated Up as Tolerated w/assistance Bedrest

Code Status: DNR/DNI Full Code Hospice Stay? Yes No

Additional Directives: _____

Diet: _____ Texture: _____

Thickened Liquids: Yes No If Yes, Consistency: _____

Supplements:

Type	Amount	Frequency

Routine Labs/Dx: _____

Oxygen: Yes No If Yes, Cannula or Mask Rate: _____

Continuous or PRN Diagnosis: _____

Therapy Evaluation/Treatment: PT OT SP

May use House Standing/Wound Orders: Yes No Level of Care: Skilled

Prognosis: Excellent Good Fair Poor Guarded Terminal

Rehab Potential: Good Fair Poor Guarded

Discharge Plan: STC < 30 days STC 31-90 days STC 90-180 days LTC > 180 days

History & Physical dated: _____ is current

All orders x 75 days unless otherwise indicated

Vaccination	Date Given	Vaccination	Date Given
Pneumovax		Tetanus	
Flu Vaccine		Other	

Mantoux	Date Given	Result	Mantoux	Date Given	Result
1 st Step			2 nd Step		

I will I will not continue to care for this patient after admission

I will I will not see this patient at the nursing home

Physician's Signature: _____ **Date:** _____

Resident: _____ Physician: _____ MR#: _____

**PROVIDENCE
PLACE**

Physical Examination

Name: _____ Date of Exam: _____

Age: _____ Weight: _____ Date of Last Exam: _____

Interval History: _____

Current Medications and Treatments: See Attached

Tuberculin Status: _____ Date of Last Chest X-ray: _____

Allergies: _____ DNR/DNI Status: _____

General Description: _____

Systematic Review and Exam:

	<u>Abnormal</u>	<u>Normal</u>	Explanation by Number
1 Head	_____	_____	
2 Eyes	_____	_____	
3 Ears, Nose, Throat	_____	_____	
4 Neck	_____	_____	
5 Chest	_____	_____	
6 Breasts	_____	_____	
7 Heart	_____	_____	
8 Abdomen	_____	_____	
9 Hernia	_____	_____	
10 Genitalia	_____	_____	
11 Pelvic	_____	_____	
12 Rectal	_____	_____	
13 Extremities	_____	_____	
14 Spine	_____	_____	
15 Peripheral Pulses	_____	_____	
16 Neurological	_____	_____	
17 Skin	_____	_____	

Rehab Potential: _____ Discharge Plan: _____

Please record the Lab Tests done at this office visit, if any: _____

Physician's Signature: _____ **Date:** _____

Resident: _____ Physician: _____ MR#: _____

Providence Place Standing Orders

All orders listed below may be used on PRN basis at the discretion of the nurse for the general comfort of the resident.

If any PRN orders are utilized more than 24 hours, a specific order from the physician must be obtained.

PAIN OR FEVER (if use exceeds 2 days, contact physician)

1. Acetaminophen 650 mg PO, liquid or rectally q4h PRN for mild aches, pain and fever
***Notify physician if temperature is >100.0 F)**

COLD SYMPTOMS

1. Robitussin DM 5-10 cc q4-6h PO PRN cough
***Notify physician if cough lasts for more than 72 hours or is accompanied by other significant changes**

GASTRIC DISTRESS

1. Maalox or Amphogel 30 cc PO q2h PRN
2. Compazine Suppository 25 mg rectally q8h for nausea and vomiting PRN
***Notify physician if distress persists for more than 4 hours**

CONSTIPATION

1. M.O.M. 30 cc PO PRN for constipation
2. If no results, may give Dulcolax or Glycerin suppository rectally
3. If no results from Dulcolax or Glycerine suppository, give Sodium Phosphate or tap water enema 500 cc of cool water PRN
***Notify physician if results are not obtained**

LOOSE STOOLS OR DIARRHEA

1. Clear liquid diet x 24 hours
2. Imodium one tablet PO PRN with each loose stool. May give up to 6 tablets in a 24 hour period
3. Kaopectate 30 cc PO PRN per each loose stool. May give up to 6 doses in a 24 hour period.
***Notify physician if condition lasts more than 24 hours**

SKIN CARE FOR MINOR CUTS, RASHES, ABRASIONS AND SKIN IRRITATIONS

1. May cleanse open areas with tap water, normal saline or wound cleanser product b.i.d. til healed
2. May apply steri-strips, butterfly bandages and/or transparent dressing PRN
3. A & D ointment topically for reddened skin PRN
4. Bacitracin ointment topically b.i.d./t.i.d. PRN

Resident: _____ Physician: _____ MR#: _____

MISCELLANEOUS

1. May use suction machine PRN
2. Flu vaccination administered annually as recommended by U.S.P.H.S.
3. Pneumovax administered per physician order
4. PT, OT, ST assessment PRN
5. Therapeutic LOA with medication PRN
6. May have alcoholic beverages unless contraindicated by the physician
7. Sutures and staples may be removed by the nursing home nurse if wound is clean and healed. Otherwise, contact physician for instructions.
8. Resident may participate in Therapeutic Recreational activities unless contraindicated by their condition
9. Toiletries may be kept at bedside
10. Aqua K pad PRN, set at 101.0 F unless specified differently by the physician
11. May replace gastrostomy tube with similar size tube PRN. May get x-ray to check placement.
12. Medications may be substituted with Generic medications
13. PRN medications or treatments that have not been administered in the past 90 days may be discontinued via telephone order without contacting the physician
14. Two step mantoux (dose as per U.S.P.H.S.) on admission or a chest x-ray if the resident has a history of a positive mantoux (or documented by the physician as contraindicated).
15. May warm pack, cold pack and/or ice pack for symptom relief
16. Resident may see Dentist, Ophthalmologist, Podiatrist or have auditory exams PRN
17. The physician and/or nurse practitioner will be notified of skin alterations/wounds
18. May be served regular diet with ordered consistency/texture on holidays, resident's birthday and special events as determined by the Registered Dietician
19. All new admissions may have a regular diet unless otherwise ordered. All diets will be physician ordered, including texture modification
*EXCEPTION: Per nursing discretion, texture may be decreased (i.e. regular to mechanical soft or mechanical soft to pureed) on a trial basis, not to exceed 24 hours before a physician order is obtained.
20. **NO MEDICATION MAY BE ADMINISTERED IV PUSH**

Physician's Signature: _____ Date: _____

Resident: _____ Physician: _____ MR#: _____

PROVIDENCE PLACE
Directives to Define Scope of Medical Care

I understand Providence Place will use full resuscitative measures until I have made a decision and the physician has validated the code status order.

Does the resident have a Health Care Declaration on file? Yes: _____ No: _____

Based on the information above, the following options have been selected. Initial all appropriate orders.

1. **TO RESUSCITATE:** Full cardiopulmonary resuscitation (CPR: forces respiration by external means, e.g. mouth to mouth breathing; closed chest compressions).
2. **DNR (Do not Resuscitate):** In the event of acute or impending respiratory arrest, no cardiopulmonary resuscitation shall be initiated.
3. **DNI (Do not Intubate):** In the event of acute or impending respiratory arrest, endotracheal to provide sustained assisted ventilation should not be performed. DNI does not prohibit emergency management to prevent or reverse acute airway obstruction.

Health Care Directives Below

Medical and Nursing care ordered by the physician which contributes to the patient's comfort, hygiene and dignity will be delivered. Specific orders include, but are not limited to the following:

	Yes	No
1. Hospitalization	_____	_____
2. IV Hydration	_____	_____
3. Comfort Care	_____	_____
4. Antibiotics	_____	_____
5. O2 Comfort	_____	_____
6. Tube Feeding	_____	_____

*Exceptions to the above: _____

***These Directives are the expressed wishes of the resident, guardian and/or family, are medically appropriate and are documented in the resident's medical record.**

To be completed by the Resident, Family or Proxy:

I have been informed of and understand the care treatment offered. I understand I may revoke these directives at any time. I give permission for this information to be given to physicians, nurses, paramedics and other health care personnel as necessary to implement these directives.

Resident/Authorized Signature: _____ Date: _____

Relationship to Resident: _____

Physician Signature: _____ Date: _____

Order Received by Dr: _____ Via: _____ Date: _____

Providence Place Representative: _____ Date: _____

Resident: _____ Physician: _____ MR#: _____