# ADMISSION ORDERS

NEW MEDICATIONS ☐ Spanish Translation

| # | Date | Medication Name | Dose | Route | Frequency | Purpose |
|---|---|---|---|---|---|---|
| 1 | 2024-06-29 | Cynide | 2 | INH | Topical | QD |
| 2 | 2024-06-22 | Panadol | 3 | Po | Topical | BID |

Treatment Orders

☑ Discontinue

☐ Refill Medications

| | |
|---|---|
| DIET | ☑ Dash ☐ Renal ☐ Diabetic ☑ Mechanical Soft ☐ Pureed ☐ Thickened Liquid |
| DME | ☐ Cane ☐ WheelChair ☑ Ankle Support ☑ ShowerChair ☑ Walker ☐ Compression Stockings ☐ BP Machine ☐ Commode ☐ Back Support ☐ Knee Support |
| SUPPLIES | ☐ Pull Ups Small ☐ Under Pads ☑ Bed Pan ☑ Pull Ups Medium ☐ Pull Ups Large ☐ Glucose Test Strips |

Refer To:

| | | | |
|---|---|---|---|
| ☑ Home Health Due To | Name of Health Agency: NIRVANA HH<br>Name of Hospice Agency: Name I cant write here... | | |
| ☑ Cardiology | Name Custom Cardiology Name | Tel: 03179666609 | Location: Somewhere |
| ☑ WoundCare | Name Some Hospital | Tel: 03179666609 | Location: 03179666609 |
| ☑ Surgery<br>Procedure: 03179666609 | Name 03179666609 | Tel: 03179666609 | Location: 03179666609 |
| ☑ Pain Specialist | Name Arslan | Tel: 03179666609 | Location: Emaar |
| ☑ Orthopaedic | Name Arslan | Tel: 03179666609 | Location: Emaar |

Laboratory and Diagnostics

| | | |
|---|---|---|
| ☑ Ans/QSART Test Evalution For Automatic Nervous System | ☑ Ultrasound Bilateral Lower Extremities Arteries And Veins | ☐ Echocardiogram |
| ☐ AIC | ☐ Pneumonia Sputum | ☐ B12 |
| ☑ Chest X-Ray, VI | ☑ Lithium Level | ☑ Renal Profile |
| ☐ VitaminD | ☐ EKG | ☑ BMP |
| ☐ Liver Profile | ☐ CBC | ☐ CT |
| ☐ Urine Culture & Sensitivity | ☑ TSH, T3, T4 | ☐ CMP |
| ☐ PSA | ☐ Cardiac Enzymes | ☑ LIPID Panel |

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

# REFERAL FORM

JesusArenasMD@cad.com | MD ID: Comes here...

Name of Agency : NIRVANA HH

**Home Health Service**

- [x] ForSkillNursingServices
- [x] ForPhysicalTherapyTreatment
- [x] ForOccupationalTherapy

**Treatment**

- [x] PainManagement
- [x] Psychiatry
- [x] Neurology
- [ ] WoundCareSpecialist

Lab(s) _____

- [ ] Lipid Panel
- [x] Renal Profile
- [ ] Urine Culture And Sensitivity
- [x] ANS/ QSART Test (Evaluation For Autonomic Nervous System)
- [ ] EKG
- [ ] TSH, T3, T4
- [x] CBC
- [ ] BMP
- [x] Cardiac Enzymes
- [ ] CT
- [ ] Liver Profile
- [ ] Echocardiogram
- [ ] CMP
- [x] Respiratory Swab
- [ ] A1C
- [ ] B 12
- [ ] Ultrasound Bilateral Lower Extremities For DVT
- [ ] Urinalysis With PCR If (+)
- [ ] PSA
- [x] Vitamin D
- [ ] Chest X-Ray
- [x] Pneumonia Sputum

Provider Name: Name Signature: _____
Date: Date here

Medical Provider Name: Name Signature: _____
Date: Date here

# IMPRESSION PLAN

☐ Transitional Care

| | |
|---|---|
| **Stroke** | Patient may have the formation of an area of necrosis in the cerebrum caused by an insufficiency of arterial or venous blood flow. Infarcts of the cerebrum are generally classified by hemisphere (i.e., left vs. Right), lobe (e.g., frontal lobe infarction), arterial distribution (e.g., infarction, anterior cerebral artery), and etiology (e.g., embolic infarction). |
| **Mucosa: Dry** | Patient may have dry mouth, a symptom that leads to a lack of saliva. Individuals with dry mouth do not have enough saliva to keep the mouth wet. |
| **Pvd** | PVD. risk factors are CAD, diabetes, high cholesterol, HTN, overweight, physical inactivity, smoking. Most commonly caused by atherosclerosis of the artery wall. Some symptoms are changes in the skin including decrease skin temperature Or shiny skin on the legs and feet, weak pulse is in legs and feet, hair loss on legs, wounds that won't heal, numbness or weakness or heaviness and muscles, numbness or coldness, or burning or aching at rest, paleness when legs are elevated And turn dusky red in dependency, Claudication (which means pain usually in the calf that occurs with exercise or walking and dissipates with rest). pain with rest in the legs occurs when the artery occlusion is so critical that there's not enough blood and oxygen supply to legs even at rest. diagnostic tests are angiogram, Doppler ultrasound, ABI. goals are to control the symptoms and hold the progression of the disease to lower the risk for heart attack, stroke, and other complications. Lifestyle changes including regular walking exercises up until claudication develops and repeating to increase walking time, proper nutrition, quitting smoking. Some medicines to improve blood ?ow are aspirin, clopidogrel, pentoxifylline, cilostazol which dilates arteries to help increase oxygenated blood ?ow thereby helping to increase physical activity w/o the pain of claudication, statins, BP meds. Don't use cilostazol in heart failure patients. Patients may require angioplasty, bypass surgery or endardectomy to get rid of the blockage. |

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Advanced Care Planning: Advanced care planning with patient, time spent **15** minutes. Reviewed care plan options such as code status, intubation and hospitalization. Reviewed risks of cardiac resuscitation including rib fracture. Reviewed prolong life expectancy and benefit to aggressive care and treatment.

## Orders: AS ATTACHED

**Discussion Notes:**

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# INITIAL ASSESMENT

| | | | |
|---|---|---|---|
| ☐ Initial Visit | ☐ Follow Up Visit / ☐ Recert Visit | Sex : ☑ M / ☐ F | Location patient is accessed: ☑ Home Visit ☑ Boarding Care |

**Chief Complaint**

**ALLERGIES**

| Drug / Food | Reaction |
|---|---|
| Name of the drug | Reaction Description |

☐ Penicillin ☐ Sulfa ☐ NO KNOWN ALLERGIES

| Functional Limitations | | Activities Permited | |
|---|---|---|---|
| ☑ Weakness | ☐ Ambulation | ☐ Up As Tolerated | ☐ Dependent At Home |
| ☐ Amputation | ☑ Bowel/Bladder | ☑ Independent At Home | ☑ Bed-Bound |
| ☐ Confused | ☐ Contacture | ☐ Cane | ☐ Chair Bound |
| ☐ Hearing | ☐ Legally Blind | ☐ Complete Bedrest | ☐ Crutches |
| ☐ Paralysis | ☐ SOB Minimum Exertion | ☑ Exercise Provided | ☑ Partial Weight |
| ☐ Speech | ☐ Vision Deficit | ☐ Walker | ☐ Wheelchair |

**PAST MEDICAL HISTORY**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Chronic Back Pain | ☐ Neuropathy | ☐ GERD | ☑ Rheumatoid Arthritis | ☑ Over Active Bladder | ☐ Gout | ☐ Depression | ☐ Sciatica |
| ☐ Osteoporosis | ☑ Insomnia | ☐ Venous Insufficiency | ☐ PVD | ☐ Glaucoma | ☐ Bipolar | ☐ Schizophrenia | ☐ Headache's |
| ☐ Bronchitis | ☑ Mild Memory Loss | ☑ CAD | ☑ Cobalamin Deficient | ☐ Dementia | ☐ BPH | ☐ Parkinson's | ☐ Cancer |
| ☐ MI | ☐ Cardiac Arrhythmia | ☐ Asthenia | ☐ Weakness | ☐ Iron Anemia | ☐ Hypothyroidism | ☐ Anxiety | ☐ COPD |
| ☐ Muscle Weakness | ☐ UTI | ☐ Tobacco Use | ☑ Chronic Falls | ☑ CHF | ☐ A.FIB | ☐ Protein Deficiency | ☐ Herniated Disc |
| ☑ Angina Pectoris | ☐ Stroke | ☑ Diabetes Type 1 2 | ☑ Diarrhea | ☐ Hypertension | ☐ Tachycardia | ☐ Asthma | ☐ CKD |
| ☑ Alzheimer's | ☐ Arthritis | ☐ Chronic Migraine | ☐ DVT | ☐ Hypertriglyceridemia | ☐ Shingles | ☐ HLD | ☐ Constipation |
| ☐ HIV | ☑ Seizure | ☑ Vertigo | ☑ Vit. D Deficient | ☐ Unsteady Gait | | | |

**PAST SURGICAL HISTORY**

| | |
|---|---|
| ☐ CABG | ☐ Hernia |
| ☐ Knee Replacement (R) | ☑ Knee Replacement (L) |
| ☐ Hip Replacement (R) | ☐ Hip Replacement (L) |
| ☐ Appendectomy | ☑ Cholecystectomy |
| ☑ Cardiac Stents | ☐ Hysterectomy |
| ☐ Pacemaker | ☐ Cataracts |

**Social History**

| | | | | | |
|---|---|---|---|---|---|
| **Tobacco / THC** | ☑ Yes | ☐ No | ☐ Daily | ☑ Socially | ☐ Occasionally |
| **ETOH/Alcohol** | ☑ Yes | ☐ No | ☐ Daily | ☑ Socially | ☐ Occasionally |
| **Drugs** | ☐ Methamphetamines | ☐ Cocaine | ☐ Heroin | ☐ Ecstasy | |

**REVIEW OF SYSTEM / PHYSICAL EXAMINATION**

**VITALS**

| HT | WT | TEMP | BP | HR | RR | 02 SAT |
|---|---|---|---|---|---|---|
| Date | Meds | Dos | Rout | Freq | Purpose | Purpose |

| System | WNL | FINDINGS |
|---|---|---|
| **General** | | ☐ Loss Weight ☐ Anorexia ☑ Immobile ☐ Cachectic ☐ Alert ☐ Awake<br>☐ Inattentive ☐ Recentlyfell ☐ Obese ☐ Chills ☐ Fatigue ☐ Gain Weight<br>☐ Fever ☐ Ataxia ☐ Limited Ambulation ☐ Night Sweats |
| **Head** | | ☐ Vertigo ☐ Masses ☐ Contusion ☑ Seizures ☐ Syncope ☐ Headache<br>☐ Abrasion ☐ Dizziness ☐ Trauma |
| **Neck, Axilla, Breasts** | | ☐ Rash ☐ Lymphadenopath ☑ Bleeding ☐ Discharge ☐ Tenderness ☐ Dowager Hump<br>☐ Pain Masses ☐ Numbness And Tingling In Neck ☐ Erythema ☐ Tracheamidline ☐ Breasts Asymmetric ☐ Neck Pain |

| System | WNL | FINDINGS |
|---|---|---|
| **Eyes** | | ☐ Decreased Vision ☐ Diplopia ☑ PERRLA ☐ ArcusSenilis ☐ Involuntary Blinking ☐ Strabismus<br>☐ Blurring ☐ Dry Eyes ☐ Glasses ☐ Erythema |
| **Ears** | | ☐ Good Light Reflex ☑ Erythematous ☐ Pain ☐ Deafness ☐ Bulging ☐ External Hearing Aid<br>☐ Tinnitus ☐ Decreased Hearing ☐ Discharge |
| **Nose** | | ☐ Congestion ☐ Redness ☑ Rhinorrhea ☐ Epistaxis |
| **Mouth** | | ☐ Dysphagia ☐ Redness ☐ Missing Teeth ☑ Sticking Out Tongue ☐ Discharge: Color ☐ Sores<br>☐ Lip Smacking ☐ Dentures ☑ Dysphasia ☐ Sore Throat ☑ Mucosa: Dry ☐ Gingival Bleeding |
| **Cardiovascular** | | ☐ At Rest ☐ Bradycardia ☑ Pale ☐ Orthopnea ☑ Palpitations ☐ Shortness Of Breath:<br>☐ Minimum ☐ Arrhythmia ☐ Tachycardia ☐ Known Murmur ☐ Chest Pain ☐ Regular Irregular Rhythm<br>☐ JVD ☐ Pacemaker ☐ Edema ☐ Moderate Exertion ☑ Extremities Pulses: +2 ☑ Sinus Rhythm<br>☐ Fatigue |
| **Pulmonary** | | |
| **Abdomen** | | ☐ RUQ ☐ LUQ ☐ Hernia ☐ Hard ☐ Distended ☐ Heartburn<br>☑ Pain ☐ Diarrhea ☐ Vomiting ☐ RLQ ☐ Nausea ☐ Constipation<br>☑ Non-Tender Masses: Loc. ☐ Soft ☐ Hypoactive ☐ Tenderness:Loc: ☐ BS Present: ☐ Hyper<br>☑ LLQ |
| **Genitourinary** | | ☐ Dysuria ☐ Hematuria ☑ Increased Frequency ☐ Foul Odor ☑ Incontinence ☐ Cloudy Urine<br>☐ Catheter |
| **Rectal** | | ☐ Bleeding ☐ Rash ☐ Hemorrhoids ☑ Discharge ☑ Wearing Diaper ☐ Redness |
| **Upper extremities** | | ☐ Radial Pulse: R ☑ Radial Pulse: Absent ☑ Numbness And Tingling Loc: L ☐ Weakness Loc: L ☐ Heberden's Node ☐ AV Shunt :<br>☐ Radial Pulse: L ☑ Numbness And Tingling Loc: R ☐ Radial Pulse: Weak ☐ Limited Movements ☐ Itchiness ☐ Edema Pitting<br>☑ AV Shunt :R ☐ Swelling Loc : L ☐ Weakness Loc: R ☐ Shaking ☐ Redness ☐ Non-Pitting: Loc: R<br>☐ AV Shunt :L ☐ Non-Pitting: Loc: L ☐ Warm ☐ Swelling Loc : R ☐ Cold |
| **Lower extremities** | | ☐ Limited Movements ☐ Weakness Loc ☑ Swelling Loc ☐ Hallux Valgus ☐ Itchiness ☐ Redness<br>☐ Shaking ☐ Edema Pitting ☐ Weakness: Loc: R ☑ Weakness: Loc: L ☐ Swelling Loc: R ☐ Swelling Loc: L<br>☐ Numbness And Tingling Loc: ☐ Numbness And Tingling Loc: R ☐ Numbness And Tingling Loc: L ☐ Cold ☐ Warm ☑ Pedal Pulse:<br>☐ Pedal Pulse: Weak ☐ Pedal Pulse: Absent ☐ Pedal Pulse: R ☐ Pedal Pulse: L |
| **Skin** | | |
| **Nutrition** | | |
| **MUSCLE SKELETAL** | WNL... | ☐ Stiffness Arm: L ☑ Stiffness Arm: R ☐ Stiffness Leg: L ☐ Stiffness Leg: R ☐ Weakness Arm: L ☐ Weakness Arm:R<br>☐ Weakness Leg: L ☐ Weakness Leg: R ☐ Kyphosis ☐ Decreased ROM ☑ Lumbar Pain |
| **Endocrine** | | |
| **Pelvic** | | ☐ Stiffness ☐ Hernia ☐ Erythema ☐ Rash ☑ Pain ☐ Trauma<br>☐ Decreased Range Of Motion |
| **Neurological** | | ☐ Facial Weakness ☐ Impaired Balance ☑ Numbness ☐ Dizziness ☐ Seizure ☐ Tremors<br>☐ Slurred Speech ☐ Grimacing ☐ Handgrip Weak: ☐ Handgrip Weak: L ☐ Handgrip Weak: R ☐ Paralysis: |

| System | WNL | FINDINGS |
|---|---|---|
| | | ☐ Paralysis: L ☐ Paralysis: R ☐ Mild Cognitive Delay/Learning Difficulties ☐ Half Body Weakness: ☐ Half Body Weakness: L ☐ Half Body Weakness: R<br>☐ Facial Drooping: ☐ Facial Drooping: L ☑ Facial Drooping: R ☐ Stuttering ☐ Non Verbal ☐ Unsteady Gait |
| **Mental** | | ☐ Lability Of Mood ☐ Hallucinations ☐ Delusions ☐ Depression ☑ Somnolence ☐ Insomnia<br>☐ Anxious ☐ Disoriented ☐ Lethargic ☑ Forgetful ☐ Confused ☐ Hearing Voices<br>☐ Oriented: ☐ Person ☐ Time ☐ Place |

**ASSESSMENT/DIAGNOSIS**

Diagnosis comes here...

**PLAN**

| | | |
|---|---|---|
| ☐ Send To ED Now | ☐ Follow Up In 1 Week With ECP | ☐ Continue Current Medications/ Treatment |
| ☐ New Med/Tx/Sup/DME: See Orders | ☐ Labs/Diagnostics: See AdmissionOrders | ☐ Referrals: See Admission Orders |
| ☐ Wellness/Preventive Intervention | ☐ PT/OT/HH For Disease Or Pain Management | ☐ Refill Medications |

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

# FACE TO FACE ENCOUNTER

**Home Health:** Home health name... **Date of Service** Date here...

I certify that this patient is under my care and that I, or an allowed Nurse practitioner or Physician's assistant working in collaboration with me, had a face-to-face encounter that meets physician face-to-face-encounter requirements with this patient on:

**Month** Month here... **Day** Day here... **Year** Year here...

**Clinical Summary of Findings from Face-to-Face Encounter in Support of Home Health Need:**
(Require up to 90 days prior to initial SOC, is relevant to the reason for the patient's need for home health services, or within 30 days after the start of care if the 90-day prior encounterdid not take place.)

**Medical Condition Related to Home Health Services:**
The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care because

| | | | |
|---|---|---|---|
| ☐ HTN | ☐ HLD | ☑ DIABETES Type 1 2 | ☐ GERD / Gout |
| ☐ COPD / Asthma / Dyspnea | ☐ Limited Ambulation | ☐ OA | ☑ Depression |
| ☐ Anxiety | ☐ Insomnia | ☐ Constipation | ☐ Hyperthyroidism |
| ☑ BPH/ Overactive Bladder | ☐ Memory Loss | ☑ Dizziness | ☐ Tobacco Use |
| ☑ Vitamin D Deficiency | ☐ Neuropathy / Sciatica | ☑ Muscle Cramp | ☐ Ble Weakness/Ble Edema |
| ☑ PVD / DVT / CAD | ☐ Schizophrenia | ☐ Arthritis / Osteoarthritis | ☐ Iron Deficiency Anemia |
| ☑ Stroke | ☐ Mild Mental Retardation | ☐ Herniated Disc | ☐ Angina Pectoris |
| ☐ Venous Insufficiency | ☐ Hypertensive Heart Disease Without Heart Failure | ☐ LBP, Knee / Shoulder Pain | ☐ Hypothyroidism |
| ☐ Myocardial Infarction | ☐ ATRIAL Fibrillation | ☑ Dementia / Alzheimer's | ☐ Cancer |
| ☐ Seizure | ☐ Hypertensive Heart Disease With Heart Failure | ☐ Nausea/Vomit/Diarrhea | ☑ Congestive Heart Failure |
| ☐ Hyperlipidemia | ☐ Chronic Migraines | ☐ Parkinson's | ☐ History Of Falls |
| ☑ Chronic Kidney Stage 1 / 2 / 3 | ☐ SOB With Exertion | ☐ Bipolar / Psychosis | ☐ Arrhythmia |
| ☐ Asthenia / Unsteady Gait | | | |

I further certify that, based on my findings, this patient is homebound (i.e. absences from home require considerable and taxing effort, and for medical reasons or religious services, or infrequently, or of short duration when for other reasons) due to the following services that are medical necessary from home health (Check allthat apply):

| | | | |
|---|---|---|---|
| ☐ Skilled Nursing | ☑ Ostomy Care | ☑ Speech Pathology | ☐ Cardiac/CHF Care |
| ☐ Home Health Aide | ☐ Occupational Therapy | ☐ Physical Therapy | ☐ Medical Management |
| ☑ Diabetic Care | ☐ Neurological Care | ☐ Foley Catheter Care | ☐ Stroke Care |
| ☐ G.T. Care | ☑ Wound Care | ☐ Strengthening/Balance | ☐ Social Worker |
| ☑ Dialysis Care / AV Fistula | ☐ Psychiatry | ☐ Orthopedic Care | ☐ COPD Care |

**Certificate of Homebound Status:**
My clinical findings from this encounter support the patient is homebound due to:

| | | | |
|---|---|---|---|
| ☑ Requires The Assistance Of 1-2 People To Ambulate | ☐ Poor Ambulation – Prone To Falls | ☑ Medical Restrictions: Open Draining Wound, Legs Elevated All Times | ☐ Impaired Ability To Unsafe To Drive |
| ☑ Confusion/Disorientation | ☑ Unable To Leave Home Without Maximum Assistance And/Or Effort | ☐ Debilitating Dizziness | ☐ Compromised Mental Status |
| ☑ Difficult And Taxing Effort To Leave Home | ☐ Unable To Ambulate | ☑ Requires An Assistive Device To Ambulate | ☐ Post-Op Weakness |
| ☐ Unsteady Gait With Assistive Device | ☑ Debilitating Dyspnea On Exertion | ☐ Unable To Negotiate Stairs | |

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

# TELE MEDICINES

**Home Health:** Home health name... **Date of Service** Date here...

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| ☐ Anxiety | ☐ Insomnia | ☐ Constipation | ☐ Hyperthyroidism |
| ☐ BPH/ Overactive Bladder | ☐ Memory Loss | ☐ Dizziness | ☐ Tobacco Use |
| ☐ Vitamin D Deficiency | ☐ Neuropathy / Sciatica | ☐ Muscle Cramp | ☐ Ble Weakness/Ble Edema |
| ☐ PVD / DVT / CAD | ☐ Schizophrenia | ☐ Arthritis / Osteoarthritis | ☐ Iron Deficiency Anemia |
| ☐ Stroke | ☐ Mild Mental Retardation | ☐ Herniated Disc | ☐ Angina Pectoris |
| ☐ Venous Insufficiency | ☐ Hypertensive Heart Disease Without Heart Failure | ☐ LBP, Knee / Shoulder Pain | ☐ Hypothyroidism |
| ☐ Myocardial Infarction | ☐ ATRIAL Fibrillation | ☐ Dementia / Alzheimer's | ☐ Cancer |
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| ☐ G.T. Care | ☐ Wound Care | ☐ Strengthening/Balance | ☐ Social Worker |
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|---|---|---|---|
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| ☐ Confusion/Disorientation | ☐ Unable To Leave Home Without Maximum Assistance And/Or Effort | ☐ Debilitating Dizziness | ☐ Compromised Mental Status |
| ☐ Difficult And Taxing Effort To Leave Home | ☐ Unable To Ambulate | ☐ Requires An Assistive Device To Ambulate | ☐ Post-Op Weakness |
| ☐ Unsteady Gait With Assistive Device | ☐ Debilitating Dyspnea On Exertion | ☐ Unable To Negotiate Stairs | |

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY**

EMSA #111B
(Effective 10/1/2014)

# Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

| | |
|---|---|
| Patient Last Name: Yousuf | Date Form Prepared: |
| Patient First Name: Saim | Patient Date of Birth: |
| Patient Middle Name: | Medical Record# |

## A Check One — CARDIOPULMONARY RESUSCITATION (CPR): If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- ☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

## B Check One — MEDICAL INTERVENTIONS: If patient is found with a pulse and/or is breathing.

☐ Full Treatment **– primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ Trial Period Of Full Treatment

☐ Selective Treatment **– goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally, avoid intensive care.

☐ Request Transfer To Hospital **only if comfort needs cannot be met in current location.**

☐ Comfort-Focused Treatment **– primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal.

☐ Request Transfer To Hospital **only if comfort needs cannot be met in current location.**

**Additional Orders:** _____

## C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

- ☐ Long-Term Artificial Nutrition, including feeding tubes
- ☐ Trial Period Of Artificial Nutrition
- ☐ No Artificial Means Of Nutrition

**Additional Orders:** _____

## D Check One — INFORMATION AND SIGNATURES:

| | | |
|---|---|---|
| Discussed with: | ☐ Patient (Patient Has Capacity) | ☐ Legally Recognized Decisionmaker |
| ☐ Advance Directive Dated Date comes here ,available and reviewed -><br>☐ Advance Directive Not Available<br>☐ No Advance Directive | **Healthcare Agent if named in Advance Directive:**<br>Name: Name<br>Phone: Phone | |

**Signature Physician:**
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

| | | |
|---|---|---|
| Print Physician Name: | Phone: | License #: |
| Physician Signature: | | Date: |

**Signature of Patient or Legally Recognized Decisionmaker:**
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

| | | |
|---|---|---|
| Print Name: Name | | Relationship (write self if patient): Relationship |
| Signature: Signature | | Date: Date |
| Mailing Address (street/city/state/zip): Address | Phone: Phone | Office Use Only: Office Use Only |

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

# MEDICATION RECONCILIATION

Phone: 03179666609
DIAGNOSIS: something wrong ALLERGIES: alot of
REVIEWED FOR CONTRAINDICATIONS: ☑ Yes ☐ No

HICN: 9hhu8778
HEIGHT: 174 WEIGHT:
REVIEWED FOR INTERACTIONS: ☑ Yes ☐ No

PHARMACY NAME:Aster
ADDRESS:Pharma Address here....
PHONE:0097156667888

| Prescribed Medications | DOSE | ROUTE | FREQUENCY | PURPOSE | REFILLS |
|---|---|---|---|---|---|
| Medicine 1 | 500mg | Po | Topical | TID | 1 |

See Attachment

# ASSIGNMENT INSURANCE

Medicare Certification: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits. I hereby authorize and instruct my insurance carrier to make payment directly to Remedial Patients Care, Inc. for benefits (payments) otherwise payable to me. I agree to personally pay for any charge that are not covered by or collected from any insurance program including any deductibles and coinsurance amounts.

I certify that all information given are correct and consent to the release of all records for payment of authorized benefits from Medical, Medicaid, or any other responsible payer be made in my behalf to Remedial Patients Care, Inc.

I understand that the Federal Patient Self -Determination Act of 1990 requires that I be made aware of my right to make healthcare decision for myself. I understand that I may guess express my wishes in a document called an Advance Directives so that my wishes may be known when I am unable to speak for myself.

1. I have a Living Will declarations ☐ Yes ☐ No
   (If yes, please provide a copy of your will.)
2. I have a Durable Power of Attorney for Health Care ☐ Yes ☐ No

| | |
|---|---|
| Name of Patient | |
| Name of Patient | Date of Birth |
| Address | |
| Signature of Patient: | Date: |

## LEGAL REPRESENTATIVE (IF PATIENT IS UNABLE TO SIGN)

Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign
Consent of Caregiver if patient is unable to sign (Must have Power of Attorney)

| | | | | |
|---|---|---|---|---|
| Name of Legal Representative: | | | | |
| Relationship: | | Telephone: | | |
| Address: | | | | |
| Unit: | Street: | City: | State: | Zip: |
| Signature of Legal Rep: | | Date: | | |
| Name of Witness: | | Sitnature: | | Date: |
| Reason patient is unable to sign: | | | | |

# ANNUAL WELLNESS

| | | | | |
|---|---|---|---|---|
| Current list of patient's providers and suppliers | Name | Speciality | Reason | |
| | sample name | sample Speciality | sample reason | |
| Special Diet<br>☑ Yes<br>☐ No | Description: | ☐ Diabetic | ☐ Dash | |
| Cognitive Impairment | ☑ None | ☐ Dimentia | ☐ Mild Memory Loss | |
| List of medication, supplement and vitamins | Please see attach | | | |
| Depression screening | Felt depressed/hopeless over the last 2 weeks | ☑ Yes ☐ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| | Little or no pleasure in doing thing over the last 2 weeks | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| Hearing loss screening | Trouble hearing television or radio when others do not | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| | Strain or struggle to hear/understand conversations | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| Home safety screening | Throw rugs, poor lighting or slippery bathtub/shower at home | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| | Lack of grab bars, bathrooms, handrails on stairs and steps at home | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| Fall risk screening | Unsteady or take longer han 30 seconds to get up and go | ☐ Yes ☑ No | Evaluation/Referrals:<br>Schedule Appointments: | Notes: |
| Advance care planning | Patient consent: I consent to discuss end-of- life issues with my healthcare provider | PATIENT SIGNATURE | | |
| | Patient has already executed an advance directive | ☐ Yes ☑ No | | |
| | If no, patient was given an opportunity to execute an Advance Directive | ☐ Yes ☑ No | | |
| | Physician statement: "Patient has the ability to prepare an Advance Directive." | YES NO | | |
| | Physician has completed a Order of Life-Sustaining Treatment, or similardocument of another name, reflecting the patient's wishes | ☐ Yes ☑ No | | |
| | Physician SIGNATURE | | | DATE |

| Preventive screening (frequency) Screened Schedule (5-10 Years) | Coverage | | | Previously Screening If YES (When) |
|---|---|---|---|---|
| **Bone mass measurements** (every 24 months) | Medicare patients at risk for developing osteoporosis | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: ☐ NEEDS |
| **Cardiovascular screening blood tests** (every 5 years) <Lipid panels> <Cholesterol> <Lipoprotein> <Triglycerides> | All asymptomatic Medicare patients (12-hour fast is required) | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: ☐ NEEDS |
| **Colorectal cancer screening, flexible sigmoidoscopy** (4 years, or once every 10 years after screening colonoscopy)<br>**Screening Colonoscopy** (every 24 months at high risk; every 10 years not at high risk)<br>**Fecal occult blood test** (annually)<br>**Barium enema** (every 24 months at high risk, every 4 years not at high risk) | Medicare patients age 50 and up; for screening colonoscopy, those at high risk, no minimum age; no minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: ☐ NEEDS |

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes screening tests** (2 screening tests per year for patient diagnosed with pre-diabetes; 1 screening per year if previously tested, but not diagnosed with pre-diabetes or if never tested) | Medicare patients with certain risk factors for diabetes or those diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible) | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☐ NEEDS |
| **Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy** (Up to 10 hours of initial training within a continuous12-month period; subsequent years up to 2 hours of follow-up training each year after initial year) | Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need) | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☐ NEEDS |
| **Glaucoma screening** (annually for patient in one or more high risk groups) | Patients with diabetes mellitus, family historyor glaucoma, African-Americans age 50 andup, or Hispanic-Americans age 65 and up | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☐ NEEDS |
| **Prostate cancer screening** (annually)<br>Digital rectal exam<br>Prostate-specific antigen test | Male Medicare patients 50 and up | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☐ NEEDS |
| **Screening PAP tests and pelvic examination** (Annually if high-risk, or child bearing age with abnormal PAP test within past 3 years; every 24 months for all other women) | Female Medicare patients | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☐ NEEDS |
| **Screening mammography** (annually) | All female patients 40 or older | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☑ NEEDS |
| **Vaccines**<br><Pneumococcal> (Once in a lifetime)<br><Seasonal influenza> (once per flu season in the fall or winter)<br><Hepatitis B> (scheduled dosages required) | All Medicare patients; may provide additional pneumococcal vaccinations based on risk and if at least 5 years have passed since previous dose; for hepatitis B, if patient is medium/high risk | Previously Screened: | ☐ Yes ☑ No | Previously Screened On: | ☑ NEEDS |