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

- [x] Discontinue
- [ ] Refill Medications

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

Refer To:

[x] Home Health Due To	Name of Health Agency: NIRVANA HH Name of Hospice Agency: Name I cant write here...
[x] Cardiology	Name Custom Cardiology Name Tel: 03179666609 Location: Somewhere
[x] WoundCare	Name Some Hospital Tel: 03179666609 Location: 03179666609
[x] Surgery Procedure: 03179666609	Name 03179666609 Tel: 03179666609 Location: 03179666609
[x] Pain Specialist	Name Arslan Tel: 03179666609 Location: Emaar
[x] Orthopaedic	Name Arslan Tel: 03179666609 Location: Emaar

Laboratory and Diagnostics

- [x] Ans/QSART Test Evalution for Automatic Nervous System
- [x] Ultrasound Bilateral Lower Extremities Arteries And Veins
- [ ] Echocardiogram
- [ ] AIC
- [ ] Pneumonia Sputum
- [ ] B12
- [x] Chest X-Ray, VI
- [x] Lithium Level
- [x] Renal Profile
- [ ] VitaminD
- [ ] EKG
- [x] BMP
- [ ] Liver Profile
- [ ] CBC
- [ ] CT
- [ ] Urine Culture & Sensitivity
- [x] TSH, T3, T4
- [ ] CMP
- [ ] PSA
- [ ] Cardiac Enzymes
- [x] 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
- [ ] Echocardiogram
- [x] Renal Profile
- [ ] CMP
- [ ] Urine Culture and Sensitivity
- [x] Respiratory swab
- [x] ANS/ QSART Test (Evaluation for Autonomic Nervous System)
- [ ] A1C
- [ ] EKG
- [ ] B 12
- [ ] TSH, T3, T4
- [ ] Ultrasound Bilateral lower extremities for DVT
- [x] CBC
- [ ] urinalysis with PCR if (+)
- [ ] BMP
- [ ] PSA
- [x] Cardiac Enzymes
- [x] Vitamin D
- [ ] CT
- [ ] Chest X-Ray
- [ ] Liver Profile
- [x] Pneumonia sputum

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

Impression / Plan DX

- [ ] 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.

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:

Lorem ipsum dolor sit amet consectetur adipisicing elit. Accusamus fugiat dolores numquam possimus quod corrupti omnis laborum ab dolorem! Velit possimus, atque amet quaerat soluta dignissimos earum similique voluptatem a.

INITIAL ASSESSMENT FORM

☐ 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

- ☑ Weakness
- ☐ Ambulation
- ☐ Amputation
- ☑ Bowel/bladder
- ☐ Confused
- ☐ Contacture
- ☐ Hearing
- ☐ Legally blind
- ☐ Paralysis
- ☐ SOB Minimum Exertion
- ☐ Speech
- ☐ Vision deficit

Activities Permited

- ☐ Up as tolerated
- ☐ Dependent at home
- ☑ Independent at home
- ☑ Bed-bound
- ☐ Cane
- ☐ Chair bound
- ☐ Complete bedrest
- ☐ Crutches
- ☑ Exercise provided
- ☑ Partial weight
- ☐ 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
- [x] Diabetes Type 1 2
- [x] Diarrhea
- [ ] Hypertension
- [ ] Tachycardia
- [ ] Asthma
- [ ] CKD
- [x] Alzheimer's
- [ ] Arthritis
- [ ] Chronic Migraine
- [ ] DVT
- [ ] Hypertriglyceridemia
- [ ] Shingles
- [ ] HLD
- [ ] Constipation
- [ ] HIV
- [x] Seizure
- [x] Vertigo
- [x] Vit. D Deficient
- [ ] Unsteady Gait

PAST SURGICAL HISTORY

- [ ] CABG
- [ ] Hernia
- [ ] Knee Replacement (R)
- [x] Knee Replacement (L)
- [ ] Hip Replacement (R)
- [ ] Hip Replacement (L)
- [ ] Appendectomy
- [x] Cholecystectomy
- [x] Cardiac Stents
- [ ] Hysterectomy
- [ ] Pacemaker
- [ ] Cataracts

Social History

Tobacco / THC

- [x] Yes
- [ ] No
- [ ] Daily
- [x] Socially
- [ ] Occasionally

ETOH/Alcohol

- [x] Yes
- [ ] No
- [ ] Daily
- [x] 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 - [x] Immobile - [ ] Cachectic - [ ] Alert - [ ] Awake - [ ] Inattentive - [ ] Recentlyfell - [ ] Obese - [ ] Chills - [ ] Fatigue - [ ] Gain weight - [ ] Fever - [ ] Ataxia - [ ] Limited Ambulation - [ ] Night sweats
Head		- [ ] Vertigo - [ ] Masses - [ ] Contusion

System	WNL	FINDINGS
		☑ Seizures ☐ Syncope ☐ Headache ☐ Abrasion ☐ Dizziness ☐ Trauma
Neck, Axilla, Breasts		☐ Rash ☐ Lymphadenopathy ☑ Bleeding ☐ Discharge ☐ Tenderness ☐ Dowager hump ☐ Pain Masses ☐ Numbness and Tingling in neck ☐ Erythema ☐ Tracheamidline ☐ Breasts asymmetric ☐ Neck pain
Eyes		☐ Decreased Vision ☐ Diplopia ☑ PERRLA ☐ ArcusSenilis ☐ Involuntary Blinking ☐ Strabismus ☐ Blurring ☐ Dry Eyes ☐ Glasses ☐ Erythema
Ears		☐ Good light reflex ☑ Erythematous ☐ Pain ☐ Deafness ☐ Bulging ☐ External Hearing Aid ☐ Tinnitus ☐ Decreased Hearing ☐ Discharge
Nose		☐ Congestion ☐ Redness ☑ Rhinorrhea ☐ Epistaxis
Mouth		☐ Dysphagia ☐ Redness ☐ Missing teeth ☑ Sticking out tongue ☐ Discharge: Color ☐ Sores ☐ Lip smacking ☐ Dentures ☑ Dysphasia ☐ Sore throat ☑ Mucosa: Dry ☐ Gingival bleeding
Cardiovascular		☐ At rest ☐ Bradycardia ☑ Pale ☐ Orthopnea ☑ Palpitations ☐ Shortness of Breath: ☐ Minimum ☐ Arrhythmia ☐ Tachycardia ☐ Known Murmur ☐ Chest Pain ☐ Regular Irregular Rhythm ☐ JVD ☐ Pacemaker ☐ Edema ☐ Moderate exertion ☑ Extremities Pulses: +2 ☑ Sinus Rhythm ☐ Fatigue
Pulmonary		
Abdomen		☐ RUQ ☐ LUQ ☐ Hernia ☐ Hard

System	WNL	FINDINGS
		☐ Distended ☐ Heartburn ☑ Pain ☐ Diarrhea ☐ Vomiting ☐ RLQ ☐ Nausea ☐ Constipation ☑ Non-Tender Masses: Loc. ☐ Soft ☐ Hypoactive ☐ Tenderness:Loc: ☐ BS Present: ☐ Hyper ☑ LLQ
Genitourinary		☐ Dysuria ☐ Hematuria ☑ Increased Frequency ☐ Foul Odor ☑ Incontinence ☐ Cloudy Urine ☐ 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 : ☐ Radial pulse: L ☑ Numbness and Tingling Loc: R ☐ Radial pulse: Weak ☐ Limited movements ☐ Itchiness ☐ Edema Pitting ☑ AV Shunt :R ☐ Swelling Loc : L ☐ Weakness Loc: R ☐ Shaking ☐ Redness ☐ Non-Pitting: Loc: R ☐ AV Shunt :L ☐ Non-Pitting: Loc: L ☐ Warm ☐ Swelling Loc : R ☐ Cold
Lower extremities		☐ Limited movements ☐ Weakness Loc ☑ Swelling Loc ☐ Hallux Valgus ☐ Itchiness ☐ Redness ☐ Shaking ☐ Edema Pitting ☐ Weakness: Loc: R ☑ Weakness: Loc: L ☐ Swelling Loc: R ☐ Swelling Loc: L ☐ Numbness and Tingling Loc: ☐ Numbness and Tingling Loc: R ☐ Numbness and Tingling Loc: L ☐ Cold ☐ Warm ☑ Pedal pulse: ☐ 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

System	WNL	FINDINGS
		☐ Stiffness Leg: R ☐ Weakness Arm: L ☐ Weakness Arm:R ☐ Weakness Leg: L ☐ Weakness Leg: R ☐ Kyphosis ☐ Decreased ROM ☑ Lumbar Pain
Endocrine		
Pelvic		☐ Stiffness ☐ Hernia ☐ Erythema ☐ Rash ☑ Pain ☐ Trauma ☐ Decreased Range of Motion
Neurological		☐ Facial weakness ☐ Impaired balance ☑ Numbness ☐ Dizziness ☐ Seizure ☐ Tremors ☐ Slurred speech ☐ Grimacing ☐ Handgrip weak: ☐ Handgrip weak: L ☐ Handgrip weak: R ☐ Paralysis: ☐ Paralysis: L ☐ Paralysis: R ☐ Mild cognitive delay/learning difficulties ☐ Half body weakness: ☐ Half body weakness: L ☐ Half body weakness: R ☐ Facial drooping: ☐ Facial drooping: L ☑ Facial drooping: R ☐ Stuttering ☐ Non Verbal ☐ Unsteady gait
Mental		☐ Lability of mood ☐ Hallucinations ☐ Delusions ☐ Depression ☑ Somnolence ☐ Insomnia ☐ Anxious ☐ Disoriented ☐ Lethargic ☑ Forgetful ☐ Confused ☐ Hearing Voices ☐ 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
- [x] DIABETES type 1 2
- [ ] GERD / Gout
- [ ] COPD / Asthma / Dyspnea
- [ ] Limited Ambulation
- [ ] OA
- [x] Depression
- [ ] Anxiety
- [ ] Insomnia
- [ ] Constipation
- [ ] Hyperthyroidism
- [x] BPH/ Overactive Bladder
- [ ] Memory loss
- [x] Dizziness
- [ ] Tobacco Use
- [x] Vitamin D deficiency
- [ ] Neuropathy / Sciatica
- [x] Muscle cramp
- [ ] Ble Weakness/Ble Edema
- [x] PVD / DVT / CAD
- [ ] Schizophrenia
- [ ] Arthritis / Osteoarthritis
- [ ] Iron deficiency anemia
- [x] 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
- [x] Dementia / Alzheimer's
- [ ] Cancer
- [ ] Seizure
- [ ] Hypertensive Heart Disease with Heart failure
- [ ] Nausea/Vomit/Diarrhea
- [x] Congestive Heart Failure
- [ ] Hyperlipidemia
- [ ] Chronic migraines
- [ ] Parkinson's
- [ ] History of Falls
- [x] 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
- [x] Ostomy Care
- [x] Speech Pathology
- [ ] Cardiac/CHF Care
- [ ] Home Health Aide
- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Medical Management
- [x] Diabetic Care
- [ ] Neurological Care
- [ ] Foley Catheter Care
- [ ] Stroke Care
- [ ] G.T. Care
- [x] Wound Care
- [ ] Strengthening/Balance

- [ ] Social Worker
- [x] 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:

- [x] Requires the assistance of 1-2 people to ambulate
- [ ] Poor ambulation – prone to falls
- [x] Medical restrictions: open draining wound, legs elevated all times
- [ ] Impaired ability to unsafe to drive
- [x] Confusion/disorientation
- [x] Unable to leave home without maximum assistance and/or effort
- [ ] Debilitating dizziness
- [ ] Compromised mental status
- [x] Difficult and taxing effort to leave home
- [ ] Unable to ambulate
- [x] Requires an assistive device to ambulate
- [ ] Post-op weakness
- [ ] Unsteady gait with assistive device
- [x] 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...

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...
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- [ ] 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
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- [ ] 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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- [ ] Chronic migraines
- [ ] Parkinson's
- [ ] History of Falls
- [ ] Chronic Kidney Stage 1 / 2 / 3
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- [ ] Bipolar / Psychosis
- [ ] Arrhythmia
- [ ] Asthenia / Unsteady Gait

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- [ ] Home Health Aide
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- [ ] 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

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

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#

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

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.

A Check One

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

MEDICAL INTERVENTIONS: If patient is found with a pulse and/or is breathing.

B Check One

- ☐ 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: _____

ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

C Check One

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

Additional Orders: _____

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive Dated
Date comes here
,available and reviewed ->
☐ Advance Directive Not Available
☐ No Advance Directive

Healthcare Agent if named in Advance Directive:
Name: Name
Phone: Phone

D Check One

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

Medication Reconciliation

Phone: 03179666609
HICN: 9hhu8778
DIAGNOSIS: something wrong
ALLERGIES: alot of
HEIGHT: 174
WEIGHT:
REVIEWED FOR CONTRAINDICATIONS:
☑ Yes
☐ No
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 of Insurance Benefits

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: