☐ **Transfer to Providence Transitional Care Center Orders (SNF)**

☐ **Transfer to Providence Extended Care Orders (LTC)**

Resident Name: _____ **DOB:** _____

GENDER: _____ **AGE:** _____ **WEIGHT:** _____ **HEIGHT:** _____

☐ **ADMISSION** ☐ **READMISSION**

PRIMARY DX: _____

SECONDARY DX: See discharge summary

CODE STATUS (CHECK ONE):

☐ CPR

☐ DNR, RN may pronounce (Note: applies only in event person has no pulse and is not breathing. DNR does not = "do not evaluate and treat". Consider completing a MOST form to address scope of treatment.)

Date of conversation: _____ Code status discussed with: _____

Or – ☐ See attached documentation of code status conversation with parties listed.

SCOPE OF TREATMENT (CHECK ALL THAT APPLY):

☐ MOST form dated: _____ (original signed form attached)

☐ Comfort One on file dated: _____ (copy of signed form attached)

☐ Other: _____

ALLERGIES:

☐ NKDA

☐ Medication allergies (indicate reaction/anaphylaxis if known): _____

_____

☐ Other allergies/sensitivities: _____

DIET Type:

☐ NPO (except liquid comfort meds)
☐ REGULAR (Heart Healthy)
☐ NAS
☐ 2-4 gram sodium restriction
☐ Renal/Dialysis
☐ Consistent Carbohydrate
☐ Calorie restriction: _____ # calories/day
☐ Fluid restriction: _____ ml/24 hours

DIET Consistency & Thickness:

☐ Whole
☐ Cut-up
☐ Chopped
☐ Chopped with ground meat
☐ Ground with bread
☐ Ground
☐ Puree
☐ Thin Liquids
☐ Nectar Thick Liquids
☐ Honey Thick Liquids

☐ Enteral Nutrition:

Route: ☐ PEG ☐ GT ☐ JT ☐ NGT

Formula Type: _____ * Dietician may change if indicated.

☐ Continuous rate: _____ ml/hour infusing _____ hours/day

☐ Intermittent (bolus) _____ ml Frequency: _____

☐ Free water: _____ ml Frequency: _____

☐ TPN – see copy of hospital TPN orders attached

☐ ST evaluation to assist in choice of food consistency and/or fluid thickness – Dx Dysphagia

☒ Nurse may downgrade & ST may upgrade diet consistency/thickness as condition indicates

Resident Name: _____ **DOB:** _____

SUPPLEMENTS:
☐ Nutritional supplement of dietician's choice – Frequency: _____ Dx: _____
☐ Protein supplement of dietician's choice – Frequency: _____ Dx: _____
☐ Other: _____ Dx: _____

ACTIVITY & THERAPIES:
☐ Weight Bearing and Activity as tolerated.

Weight Bearing Status & Precautions:
☐ RUE: _____
☐ LUE: _____
☐ RLE: _____
☐ LLE: _____

ROM Precautions:
☐ RUE: _____
☐ LUE: _____
☐ RLE: _____
☐ LLE: _____

Hip Precautions:
☐ Anterior
☐ Posterior
☐ Global

☐ Other activity or mobility restrictions: _____
☐ Sternotomy Precautions - Duration: _____
☐ Recent Pacemaker or Implanted Device Precautions – Limb & Duration: _____

☐ Brace/Splint order: _____ Wearing schedule: _____

☐ PT Evaluation & Management for: _____ Dx: _____
☐ OT Evaluation & Management for: _____ Dx: _____
☐ ST Evaluation & Management for: _____ Dx: _____
  ☐ Dysphagia Eval/Mgt (upgrade/downgrade diet as indicated) Dx: _____
  ☐ Cognitive Evaluation Dx: _____
  ☐ Speech & Language Evaluation & Management for: Dx: _____

RESPIRATORY:
☐ BiPAP Q NOC & PRN SOB settings: _____ O2 ____ L bleed Dx: _____
☐ CPAP Q NOC & PRN SOB settings: _____ O2 ____ L bleed Dx: _____
☐ Suction & Pulmonary toilet PRN secretion/sputum management Dx: _____
☐ Incentive spirometer QID and PRN while awake. Duration: _____ Dx: _____
☐ Tracheostomy management per PALTCS protocol.
☐ O2 ____ L NC/Trach humidified ☐ Continuous ☐ Q NOC Dx: _____
☐ O2 ____ L NC/Trach humidified PRN to keep Pox > _____ % Dx: _____
☐ O2 ____ L NC/Trach humidified PRN SOB or breathlessness
☐ Other RT: _____ Dx: _____

BLADDER:
☐ Follow nursing protocol for recent foley removal.
☐ Remove foley catheter _____ and follow nursing protocol for recent foley removal.
☐ Foley catheter management per nursing protocol – Dx: _____Size: _____
  ☐ Temporary ☐ Permanent
☐ Straight cath Q ____ HR and record amount drained – Dx: _____
☐ Check bladder scan Q ____ hours and straight cath for > _____ ml - Dx: _____
☐ Suprapubic catheter management – Dx: _____

OTHER LINES, TUBES, & DRAINS to be managed per nursing protocol:
☐ IV Access Type, Size, & Location: _____
  ☐ Permanent
  ☐ Temporary: Instructions for removal of IV access: _____

Resident Name: _____ **DOB:** _____

☐ May use Alteplase per protocol PRN occluded central venous catheter.
☐ PEG ☐ GT ☐ JT
☐ Colostomy ☐ Ileostomy ☐ Urostomy ☐ Nephrostomy
☐ Dialysis Access – Type & Location: _____
☐ Drains – Type & Location: _____
☐ Other: _____

WOUND & SKIN CARE:
☒ Follow recommendations of the Wound Team for treatment for all wounds and skin conditions beyond the scope of established PALTCS nursing protocols unless otherwise directed by the physician.
☐ Therapeutic surface: _____Dx: _____
☐ Wound Vac management per nursing protocol.
Indication: _____ Location: _____
Settings: _____ Change frequency: _____ & PRN
☐ Surgical incision location & instructions: _____

LABS/IMAGING:
☐ PT/INR
When: _____ Dx: _____ Goal INR: ____ Duration of therapy: _____
☐ Fingerstick glucose checks to coincide with sliding scale insulin orders (Dx DM)
☐ Fingerstick glucose checks: _____ (Dx DM)

Test/Study	**When and/or Frequency**	**Diagnosis/Indication**

Follow up appointments and consultations:

F/U with: _____ Date & Time: _____or ☐ call for appt

F/U with: _____ Date & Time: _____or ☐ call for appt

☐ Pacemaker checks per facility protocol

☐ Hemodialysis Days: _____

☐ Peritoneal Dialysis schedule and orders: _____

_____

Infection Control Precautions:
☐ MRSA site: _____
☐ VRE site: _____
☐ C. Diff
☐ Other (include site): _____

Resident Name: _____ **DOB:** _____

Additional orders:

Medications: Pharmacist may substitute equivalent Rx based on facility or insurance formulary as needed unless otherwise specified by physician. "DAW" = Dispense as Written
*******All medication orders need to have an associated diagnosis/indication per federal regulations
*******Include a stop date/anticipated duration of therapy for all anti-infectives or anticoagulants
☒ See attached SNF transfer medication orders

TB screening: Unless done within 60 days prior to admission, a Quantiferon Gold (QFT-G) blood test will be drawn per PALTCS policy.

Immunizations: Theses vaccines will be given as standing orders unless Resident is being treated for end of life or otherwise contraindicated per the physician: Pneumococcal, Influenza, Diptheria/Tetanus, Zoster are given according to the facility policy unless otherwise indicated.

I certify that continued care at the following level of care is required:

CHECK ONE: ☐ **Skilled** ☐ **Intermediate**

Certifying Physician Name: _____ **& Signature:** _____

Date signed: ____/____/_____ **Time:** _____

PALTCS use only:

☐ **Admitting Orders (pages 1-4) Verbally Reviewed with PALTCS Physician, Modified where appropriate, and Approved:**

Print Physician Name: _____ **Date:** ___/___/_____ **Time:** _____

Print RN Name: _____ **RN Signature:** _____

☐ **Admitting Orders (pages 1-4) Reviewed, Modified where appropriate, and Approved:**

Physician Signature: _____ **Date:** ___/___/_____ **Time:** _____

PROVIDENCE Extended Care

920 Compassion Circle
Anchorage, Alaska 99504

PROVIDENCE Transitional Care Center

910 Compassion Circle
Anchorage, Alaska 99504

Providence Anchorage Long Term Care Services
Medication Orders

(SMOKE FREE CAMPUSES)

Choose One: ☐ **PEC** ☐ **PTCC**

Resident/Patient Name: _____ **DOB:** _____

Transferring Facility: _____

Medications: Pharmacist may substitute equivalent Rx based on facility or insurance formulas as needed unless otherwise specified by physician. "DAW" = Dispense as Written
****All medication orders must have an associated diagnosis/indication per federal regulations**
****Include a stop date/anticipated duration of therapy for all anti-infectives or anticoagulants**

	Medication (Dose, Route and Frequency)	**Diagnosis/Indication**
1.	RX:	DX:
2.	RX:	DX:
3.	RX:	DX:
4.	RX:	DX:
5.	RX:	DX:
6.	RX:	DX:
7.	RX:	DX:
8.	RX:	DX:
9.	RX:	DX:
10.	RX:	DX:
11.	RX:	DX:
12.	RX:	DX:
13.	RX:	DX:
14.	RX:	DX:
15.	RX:	DX:
16.	RX:	DX:
17.	RX:	DX:
18.	RX:	DX:
19.	RX:	DX:
20.	RX:	DX:

X_____ X_____ **Date:**____/____/____ **Time:**_____
Transferring Physician Printed Name **Signature**
Do not sign below this line

X_____ X_____ **Date:**____/____/____ **Time:**_____
PALTCS Admitting Physician Printed Name **Signature**

X_____ X_____ **Date:** ____/____/____ **Time:**_____
PALTCS RN Printed Name **Signature**