

Patient Name: _____ Age: _____ DOB: _____ MR#: _____
 Community Transfer: _____ Direct Admit: Hospital/Unit: _____
 *Has community nurse contacted primary care MD to notify of transfer: Y N

Nurse for report: _____ Tel # _____

Symptoms: _____ Level of Care: GIP Routine Respite

Diagnoses/PMH: _____

DNR: Y N Admit Packet done: Y N HCP Name: _____ Tel: _____

Has pt/family been educated GIP vs Routine & potential financial obligation, R&B \$ 400/day: Y N

NEURO: A&O: Y N Vision: WNL Hearing: WNL Seizures: Other: _____

INTAKE: Meals Y N _____% Fluids Y N Other Comments: _____

CARDIO: AICD? Y N Pacer? Y N Other Comments: _____

RESP: Oxygen: Y N Flow: _____ O2 Sat: _____ Pleurx: Y N Drainage orders: _____

GI: LBM _____ Nausea Vomiting G-Tube NG Tube Ostomy Type: _____

*Suction Machine required: Y _____ HCS Order w/ plan to deliver for pt arrival:

Cont Inc Foley SP Cath Nephrostomy Tubes: Bil Left Right

ABILITY/SAFETY: Independent 1/2 Assist Bedbound Falls Notes: _____

Skin Integrity: Wound: Location/Description: _____
 Dressing Orders: _____

IV ACCESS: Periph R/L Date insert: _____; Portacath RCW/LCW Access date: _____; PICC R/L dsg date: _____

ALLERGIES: _____

MEDICATION	DOSE	RTE	NOTES(meds administered to treat symptoms)

**If pt on IV meds because cannot tolerate PO or requires a pump -run by MD as may need to order in advance as LTC pharmacy has 4 hr turn around.

PRECAUTIONS: N/A MRSA VRE CDiff ESBL Notes/other: _____

CHARGE PLAN: Back to community Potential placement Routine at House

ADDITIONAL INFO: (WT loss, abnormal labs, psychosocial, financial concerns etc)