Name	**DOB**
Attending Physician	**@ HM**
Code Status ☐ Code ☐No Code per discussion with _____ on ___/___/___	
ALLERGIES/ADVERSE DRUG REACTIONS	
Admission ☐ New ☐ Re-Admission: Use physician's orders from previous admission ***(amend, initial, date and attach)***	
H & P ☐ Attached ☐ Dictated ☐ Use copy of H&P from acute admission if done within 5 days of SNF admission ***(amend, initial, date and attach)***	
Diagnosis List	
Goals of Care	
Rehab Potential ☐Good ☐Fair ☐Poor	**Discharge Goal**
Eval & Tx ☐PT ☐ OT ☐Swallow ☐Speech ☐MEP	**Weight Bearing Status**
Diet ☐Regular ☐Minced ☐Ground ☐Pureed ☐Other _____	
Fluids ☐Thin ☐Nectar ☐Honey ☐Pudding ☐FR	**Activity Level** ☐As tolerated
Pass PRN with responsible person ☐Yes ☐No	**Weights** ☐Daily ☐Weekly ☐Monthly ☐Other
Restraint	**Reason for restraint use**
TB skin test (On admission & annually per policy unless resident has documented positive TB skin test)	
Pneumovax (unless previous pneumovax documented after age 65) 0.5 ml IM	**Influenza Vaccine** (Annually) 0.5 ml IM
Fingerstick blood sugar ☐Daily ☐Twice per day ☐QID AC & HS	
Labs	**Diagnosis**
Other Orders	

Another brand of drug identical form and content may be dispensed unless checked ☐				
Medication	**Dosage**	**Route**	**Frequency**	**Diagnosis**

☒Tylenol 650 mg PO/GT/NGT/PR Q 4° prn T ≥ 100°, please notify MD.
Do not exceed 4 grams/24 hours.

☒Tylenol 650 mg PO/GT/NGT/PR Q 4° prn pain.
Do not exceed 4 grams/24 hours.

☒MOM 30 cc for no BM x 2 days PO/GT/NGT

☒Dulcolax Suppository PR if no BM x 3 days

☒Fleets Enema 1 PR if no result from suppository if no BM x 4 days

LEVEL OF CARE:
☐SNF ☐ICF ☐other _____
I certify that post-hospital Nursing Facility services are required to begin on an in-patient basis because of the named patient's need for nursing care on a continuing basis for the condition(s) for which he received in-patient hospital serves prior to his transfer to the Nursing Facility. The Patient Care Plan has been initiated. I certify that the patient or his family/responsible party has been apprised of his diagnosis, condition, and prognosis per "Patient Bill of Rights" unless medically contraindicated because:

_____

PHYSICIAN'S SIGNATURE	**DATE**	**TIME**
Patient Name:		