Lourdes Senior Community
Mendelson Home
Physician's Plan of Care
RESIDENT INFORMATION

RESIDENT _____ **SEX (M/F)** _____ **DOB** _____

Current Location:_____

Transferring to: _____

Allergies:_____

Diagnosis:_____

Current Prescriber:_____**Physician Transferring to:**_____

MEDICATIONS – Please identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	(√) If Self-Administered
Please attach a written prescription for each medication the resident is currently taking including over the counter medication.				

I Certify that these orders are valid for two cycles plus PRN refills unless otherwise specified
Orders for Controlled Substances must be accompanied by an original prescription order

Prescriber's Name:	DEA# & NPI#:	
Address:	City:	State and Zip Code:
Telephone:	Fax:	
Prescriber Signature:	Date:	

Physician Signature: _____ Date _____

PHYSICIAN PLAN OF CARE CONTINUED

RESIDENT NAME: _____

Date of most recent examiniation by resident's primary care physician___/___/___

WOUNDS: _____ YES _____ NO TX ORDERS: _____

Is applicant capable of self-administering their own medications _____ YES _____ NO

SIGNIFICANT SURGICAL HISTORY:

1._____
2._____
3._____
4._____

DIET:

Regular ☐ NAS (No Added Salt) ☐

Mechanical Soft ☐ CCD (Carbohydrate Controlled) ☐

Pureed ☐ Other ☐

LIQUIDS CONSISTENCY:

Thin ☐ Honey ☐

Nectar ☐ Pudding ☐

Dietary Supplement ____YES ___NO Frequency _____

DIABETIC ___YES ___NO

Check Blood Sugar per Glucometer _____Every AM
_____ Twice a day
_____ PRN Signs/Symptoms Hyper/hypoglycemia
_____ Other

INSULIN ORDERS:_____
_____
_____

OXYGEN: _____ Yes _____ No _____ liters per minute (per nasal cannula)

Does resident require assistance with use of oxygen: _____ YES _____ NO

ADAPTIVE DEVICES: _____ wheelchair
_____ walker
_____ cane

Is resident continent of Bladder ___YES ___ NO
Is resident continent of Bowel? ___ YES ___ NO

Flu Vaccine Administered _____YES _____NO Date Administered: _____
Pneumonia Vaccine Administered _____YES _____NO Date Administered: _____

PHYSICIAN PLAN OF CARE CONTINUED

RESIDENT NAME: _____

CHEST X-RAY: (Must have been completed within the last 12 months)

Date: _____ Results: _____

Resident is freee of communicable disease _____YES ____ NO

PHYSICIAN COMMENTS:

_____

_____

_____

Physican's Name

_____ Date: _____

Physician's Signature

Physician Phone Number: _____ Physician Fax Number:_____

**The Physican Signature on this Physician Plan of Care is considered a direct order from the physician and will be carried out by the nursing staff as such.