

St. Paul's Villa



Physician's Report Package

- Pages 1 - 6** **Physician's Report for Residential Care Facilities for the Elderly**
To be completed and signed by physician
- Page 7** **Physician's Order for Medications (for prescription medications)**
To be completed and signed by physician
- Page 8** **Physician's Orders (for over-the counter /PRN "as needed" medications)**
To be completed and signed by physician
- Page 9** **Physician's Orders (for any non-medication related orders)**
To be completed and signed by physician
- Page 10 - 11** **Physician's Orders for Life-Sustaining Treatment (POLST)**
This form is used in the event of an emergency requiring emergency response. This is required, even if you already have an advanced directive.
Please complete this form before giving it to the doctor to sign.

Please return the completed Physician's Report Package, along with the Application,
to

St. Paul's Villa
Admissions Department
2340 Fourth Avenue
San Diego CA 92101
Phone: 619-232-2996
FAX: 619-232-0451

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)**I. FACILITY INFORMATION** *(To be completed by the licensee/designee)*

1. NAME OF FACILITY ST. PAUL'S VILLA		2. TELEPHONE (619) 232-2996	
3. ADDRESS 2340 FOURTH AVENUE		CITY SAN DIEGO	ZIP CODE 92101
4. LICENSEE'S NAME ST. PAUL'S EPISCOPAL HOME, INC.		5. TELEPHONE (619) 232-2996	6. FACILITY LICENSE NUMBER 370804823

II. RESIDENT/PATIENT INFORMATION *(To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE
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III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION*(To be completed by resident/resident's legal representative)*

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE
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IV. PATIENT'S DIAGNOSIS *(To be completed by the physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. **THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE.** The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered. *(Please attach separate pages if needed.)*

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE
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6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
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e. Results: mm _____ f. Action Taken (if positive): _____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

 Active TB Disease Latent TB Infection No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

- Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.
- Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

- a. Treatment/medication (type and dosage)/equipment:
- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

11. ALLERGIES:

- a. Treatment/medication (type and dosage)/equipment:

- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

- a. Treatment/medication (type and dosage)/equipment:

- b. Can patient manage own treatment/medication/equipment? Yes No
- c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (if applicable)	EXPLAIN
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to Follow Instructions			
g. Depressed			
h. Suicidal/Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
k. Able to Leave Facility Unassisted			
15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self			
b. Able to Dress/Groom Self			
c. Able to Feed Self			
d. Able to Care for Own Toileting Needs			
e. Able to Manage Own Cash Resources			
16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications			
b. Able to Administer Own Injections			
c. Able to Perform Own Glucose Testing			
d. Able to Administer Own PRN Medications			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

17. AMBULATORY STATUS:

- a. This person is considered: Ambulatory Nonambulatory Bedridden

Nonambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

- b. If resident is nonambulatory, this status is based upon:

Physical Condition Mental Condition Both Physical and Mental Condition

- c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

- Illness: _____
- Recovery from Surgery: _____
- Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

- d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)
2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain: _____

- e. Is resident receiving hospice care?

No Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: Good Fair Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE
()

22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT

23. PHYSICIAN'S SIGNATURE

24. DATE

OVER-THE-COUNTER/PRN MEDICATIONS

COMPUTRAN
SYSTEMS, INC.

Family ID	FACILITY NAME	RESIDENT CONDITION CODES
	ST. PAUL'S VILLA	

PHYSICIAN'S ORDERS

PLEASE CROSS OUT ALL HANDWRITTEN INFORMATION THAT SHOULD NOT BE PROCESSED.

Order No.	ORDER DATE	DOC DATE	DIAGNOSIS CODE	PHYSICIAN'S ORDER	SIG. CODE	HOURS
				<p>TYLENOL (ACETAMINOPHEN) 650 MG PO Q4H PRN PAIN</p> <p>TYLENOL 650 MG PO Q4H PRN TEMPERATURE 101 OR ABOVE (ORAL)</p> <p>MILK OF MAGNESIA 30 ML PO QD PRN CONSTIPATION</p> <p>DULCOLAX (BISACODYL) SUPPOSITORY 10 MG 1 RECTALLY Q3RD DAY PRN CONSTIPATION IF MOM INEFFECTIVE</p> <p>FLEET ENEMA X1 RECTALLY Q3DAYS IF DULCOLAX SUPPOSITORY INEFFECTIVE</p> <p>MAY GIVE FLU VACCINE 0.5 MG ANNUALLY IF NOT ALLERGIC TO VACCINE: CHICKEN OR EGGS DATE LAST GIVEN _____</p> <p>IMMODIUM AD 1 TAB PO AFTER EACH LOOSE STOOL MAX DOSE 6/24 HRS</p> <p>ROBITUSSIN DM 30 MG PO Q 6H PRN COUGH</p> <p>GENERIC EQUIVALENT OF DRUGS MAY BE DISPENSED UNLESS OTHERWISE INDICATED BY PHYSICIAN</p> <p>CONTINUE ABOVE ORDERS FOR 90 DAYS UNLESS OTHERWISE SPECIFIED</p>		
				<p>PHYSICIAN'S SIGNATURE _____</p> <p>DATE _____</p>		

DATE	REVIEWED BY	CHECKED BY	DATE OF BIRTH	GIVEN FAC.	PAGE

PHYSICIAN	PHONE	ALTERNATE PHYSICIAN	ALT. PHONE

ALLERGIES (PARENTHESEIZE FOOD ALLERGIES TO TRANSFER TO DIET MONITOR) RESTORATIVE POTENTIAL/PROGNOSIS

RESIDENT	CLINICAL REC. NO.	Admission Date	Ward	Room	Bed	Age	Sex



Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A GARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

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)

B MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

Comfort Measures Only Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital only if comfort needs cannot be met in current location.**

Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
 Transfer to hospital only if comfort needs cannot be met in current location.

Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

Additional Orders: _____

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

Check One

No artificial means of nutrition, including feeding tubes. Additional Orders: _____

Trial period of artificial nutrition, including feeding tubes. _____

Long-term artificial nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

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

Advance Directive dated _____ available and reviewed → Health Care Agent if named in Advance Directive:
 Name: _____
 Phone: _____

Advance Directive not available

No Advance Directive

Signature of Physician
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker

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 individual who is the subject of the form.

Print Name:	Relationship: (write self if patient)	
Signature: (required)	Date:	
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**Patient Information**

Name (last, first, middle):	Date of Birth:	Gender: M F
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Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:
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Additional Contact

Name:	Relationship to Patient:	Phone Number:
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Directions for Health Care Provider**Completing POLST**

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED