St. Paul's
SENIOR SERVICES

Physician's Report Package

BEFORE YOU GIVE THIS DOCUMENT TO YOUR PHYSICIAN, please:

- Complete Page 1, Section II (Resident/Patient information)
- Complete and sign Section III (Authorization)
- Complete the POLST form (last two pages). This form is used in the event of an emergency requiring emergency response. This is needed, even if you already have an advanced directive. Your physician will want to review this with you before signing.

PHYSICIAN TO COMPLETE AND SIGN FOLLOWING PAGES:

Physician's Report for Residential Care Facilities for the Elderly (pages 1 – 6)

Admission Orders (Physician's Orders for prescription medications)

Standing Orders (Physician's Orders for over-the counter /PRN "as needed" medications)

Additional Orders (Physician's Orders for any non-medication related orders)

Physician's Orders for Life-Sustaining Treatment (POLST)

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

The Manor
on Bankers Hill
Admissions Department
2635 Second Avenue
San Diego, CA 92103
Phone: 619-239-2097
Fax: 619-677-3895

THE MANOR
ON BANKERS HILL

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		2. TELEPHONE
The Manor on Bankers Hill -		(619) 239-2097
3. ADDRESS	**CITY**	**ZIP CODE**
2635 Second Ave.	San Diego	92103
4. LICENSEE'S NAME	**5. TELEPHONE**	**6. FACILITY LICENSE NUMBER**
St. Paul's Episcopal Home, Inc.	(619) 591-0600	370800558

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

1. NAME	2. BIRTH DATE	3. AGE

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

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

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:
			☐ Negative ☐ Positive

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. 1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:
☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is 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/or a person who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

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**

Admission Orders

Resident:	Age:	DOB:	

GENERAL ORDERS		**Comments/Instructions**
Resident is capable of self-administering medications?	☐ yes ☐ no	
Resident is permitted to consume alcohol?	☐ yes ☐ no	
Resident's current medications require crushing? If yes, list.	☐ yes ☐ no	
DNR Status		

ROUTINE MEDICATIONS (OR ATTACH ELECTRONIC MEDICATION LIST)

Medication	**Strength/Dose/Route/Frequency**

PRN MEDICATIONS (IN ADDITION TO STANDING ORDERS ON NEXT PAGE)

Please initial next to the statement that best describes this resident:

	My patient can determine and clearly communicate his/her need for prescription and nonprescription PRN medication.
	My patient cannot determine his/her own need for prescription and nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.
	My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot communicate his/her symptoms indicating a need for nonprescription medication. (Must contact physician before each dose)

Medication	**Strength/Dose/Route/Frequency**	**Symptom/Reason**	**Max Dose in 24^{o}**

Physician's Signature/Title:	**Date:**
Print name:	

Resident Name: _____

STANDING ORDERS
The following are standing orders that we would like to institute for your patient.
Please line out any orders that you do not approve of.

	Instructions (please complete if blank)
Influenza vaccination	Annually
Pneumococcal vaccine	
Tylenol, 325 mg	po 2 tabs every 4 hours prn for fever over 100 degrees not to exceed 6 tablets in a 24 hour period
Tylenol, 325 mg	po 2 tabs every 4 hours prn for pain not to exceed 6 tablets in a 24 hour period
Imodium AD, 2 mg	po for diarrhea, 2 caps initially, then 1 cap after each loose stool until diarrhea is controlled.
Robitussin DM	30 mg po every six hours prn for cough
Mylanta	30 cc po every 4 hours prn for stomach upset, notify MD if persists over 48 hours
Milk of Magnesia	30 cc po every day prn for constipation
Dulcolax, 10 mg	1 rectally for constipation not relieved within 24 hours after milk of magnesia given
Fleet enema	Give rectally every 3 days if suppository ineffective
Minor cuts/abrasions	1) Clean with wound cleaner (or soap and warm water), pat dry, 2) apply antibiotic ointment, 3) cover with band-aid dressing, 4) change daily as needed, 5) observe daily for signs and symptoms of infection: increased redness, swelling, pain, drainage or temperature. 6) If resident experiences any of these symptoms notify MD. 7) Discontinue when healed.
Minor skin tears	1) Wash with wound cleaner (or soap and warm water). 2) Apply non-stick dressing and steri-strips, change as needed. 3) Allow steri-strips to remain in place until they fall off. 4) Observe daily for signs and symptoms of infection: increased redness, swelling, pain, drainage or temperature. 6) If resident experiences any of these symptoms notify MD. 7) Discontinue when healed.
Generic Medications	**May be dispensed unless otherwise noted by physician** ☐ **Yes** ☐ **No**

If you approved of the above orders for the resident named, please sign below. If you do not approve of any of the orders, please line out the order. These orders will be in effect until such time as they are discontinued by yourself or another authorized prescriber. Thank you for your time and cooperation.

Physician's Signature/Title:	**Date:**
Print name:	

ADDITIONAL ORDERS

Resident Name: _____

Medication	Strength/Dose/Route/Frequency
PRN MEDICATIONS	

Medication	Strength/Dose/Route/ Frequency	Symptom/Reason	Max Dose in 24^{o}

Physician's Signature/Title:	**Date:**
Print name:	

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

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 — CARDIOPULMONARY 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** (**A**llow **N**atural **D**eath)

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.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — INFORMATION AND SIGNATURES:

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

☐ Advance Directive dated _____ available and reviewed →

☐ Advance Directive not available

☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

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

Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:

Additional Contact

Name:	Relationship to Patient:	Phone Number:

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