PHYSICIAN’S REPORT PACKAGE

This package contains:

- Physician’s Report for Residential Care Facilities for the Elderly (RCFE) (LIC 602A)
- Standing orders for P.R.N. Medications (meaning "when necessary" from the Latin pro re nata).
- Physician Orders for Life-Sustaining Treatment (POLST)

Before you give this document to your physician:

- Complete Page 1, Section II (Resident/Patient Information)
- Complete Page 1, Section III (Authorization for Release of Medical Information)
- Discuss your wishes with loved ones and your health profession, have your physician completed the POLST. This is needed even if you have an Advanced Directive on file. The Advanced Directive outlines your desire for future treatment; the POLST provides orders for the physician so your wishes can be carried out during emergency treatment.

THE COMPLETED PHYSICIAN’S REPORT MUST BE ACCOMPANIED BY A CURRENT MEDICATION LIST SIGNED BY THE PHYSICIAN.

Please return the completed Physician’s Report Package to:

St. Paul’s Villa
Admissions Department
2340 Fourth Ave
San Diego CA 92101
Phone: (619) 232-2996
Fax: (619) 677-3895
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 Ave
   San Diego CA

   CITY
   ZI P CODE
   92101

4. LICENSEE’S NAME
   St. Paul’s Episcopal Home

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

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>ASSISTIVE DEVICE (If applicable)</th>
<th>EXPLAIN</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>a. Auditory Impairment</td>
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<tr>
<td>b. Visual Impairment</td>
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<tr>
<td>c. Wears Dentures</td>
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<tr>
<td>d. Wears Prosthesis</td>
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<tr>
<td>e. Special Diet</td>
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<tr>
<td>f. Substance Abuse Problem</td>
<td></td>
<td></td>
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<tr>
<td>g. Use of Alcohol</td>
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<td></td>
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<tr>
<td>h. Use of Cigarettes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>i. Bowel Impairment</td>
<td></td>
<td></td>
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<tr>
<td>j. Bladder Impairment</td>
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<td></td>
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<tr>
<td>k. Motor Impairment/Paralysis</td>
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<tr>
<td>l. Requires Continuous Bed Care</td>
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<td></td>
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<tr>
<td>m. History of Skin Condition or Breakdown</td>
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</tbody>
</table>
### 14. MENTAL CONDITION

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>EXPLAIN</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Confused/Disoriented</td>
<td></td>
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<tr>
<td>b.</td>
<td>Inappropriate Behavior</td>
<td></td>
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<tr>
<td>c.</td>
<td>Aggressive Behavior</td>
<td></td>
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</tr>
<tr>
<td>d.</td>
<td>Wandering Behavior</td>
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<tr>
<td>e.</td>
<td>Sundowning Behavior</td>
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<td>f.</td>
<td>Able to Follow Instructions</td>
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<tr>
<td>g.</td>
<td>Depressed</td>
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<tr>
<td>h.</td>
<td>Suicidal/Self-Abuse</td>
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<td></td>
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<tr>
<td>i.</td>
<td>Able to Communicate Needs</td>
<td></td>
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<tr>
<td>j.</td>
<td>At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items</td>
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<tr>
<td>k.</td>
<td>Able to Leave Facility Unassisted</td>
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</tbody>
</table>

### 15. CAPACITY FOR SELF-CARE

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>EXPLAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Able to Bathe Self</td>
<td></td>
<td></td>
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<tr>
<td>b.</td>
<td>Able to Dress/Groom Self</td>
<td></td>
<td></td>
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<tr>
<td>c.</td>
<td>Able to Feed Self</td>
<td></td>
<td></td>
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<tr>
<td>d.</td>
<td>Able to Care for Own Toileting Needs</td>
<td></td>
<td></td>
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<tr>
<td>e.</td>
<td>Able to Manage Own Cash Resources</td>
<td></td>
<td></td>
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</tbody>
</table>

### 16. MEDICATION MANAGEMENT

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>EXPLAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Able to Administer Own Prescription Medications</td>
<td></td>
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<tr>
<td>b.</td>
<td>Able to Administer Own Injections</td>
<td></td>
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<tr>
<td>c.</td>
<td>Able to Perform Own Glucose Testing</td>
<td></td>
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<tr>
<td>d.</td>
<td>Able to Administer Own PRN Medications</td>
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<tr>
<td>e.</td>
<td>Able to Administer Own Oxygen</td>
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<tr>
<td>f.</td>
<td>Able to Store Own Medications</td>
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</tbody>
</table>
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:

THIRD FORM MUST BE ACCOMPANIED BY A CURRENT MEDICATION LIST SIGNED BY THE PHYSICIAN

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE  22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT
   (   )

23. PHYSICIAN'S SIGNATURE  24. DATE
STANDING ORDERS

The following are standing orders we would like to institute for your patient.

<table>
<thead>
<tr>
<th>Influenza Vaccination</th>
<th>Annually</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Tylenol, 325 mg</th>
<th>PO 2 tabs every 4 hours PRN for pain or fever 100 degrees or above, not to exceed 6 tablets in a 24 hour period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imodium AD, 2 mg</td>
<td>PO for diarrhea, 2 caps initially, then 1 cap after each loose stool until diarrhea is controlled</td>
</tr>
<tr>
<td>Robitussin DM</td>
<td>10 ML PO every 6 hours PRN for cough</td>
</tr>
<tr>
<td>Mylanta</td>
<td>30 CC PO every 4 hours PRN for stomach upset, notify MD if persists over 48 hours</td>
</tr>
<tr>
<td>Milk of Magnesia</td>
<td>30 CC PO every day PRN for constipation</td>
</tr>
<tr>
<td>Dulcolax, 10 mg</td>
<td>1 rectally every 3 days for constipation not relieved within 24 hours after Milk of Magnesia given</td>
</tr>
</tbody>
</table>
| Minor skin tears/abrasions | 1) clean with wound cleaner (or soap & warm water)  
                              2) Apply non-stick dressing or steri-strips, change as needed  
                              3) Notify MD if resident experiences any symptoms of infection: increased redness, swelling, pain, drainage or temperature  
                              4) Discontinue when healed |

Please line out any orders you do not approve. These orders will stay in effect until such time as they are discontinued by yourself or another authorized prescriber. Please sign below.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Please Print Name/Title: 
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

A CARDIOPULMONARY RESUSCITATION (CPR):

☐ 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:

☐ Full Treatment – primary goal of prolonging life by all medically effective means.
   In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
   ☐ Trial Period of Full Treatment.

☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
   In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
   ☐ Request transfer to hospital only if comfort needs cannot be met in current location.

☐ Comfort-Focused Treatment – primary goal of maximizing comfort.
   Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders:

C ARTIFICIALLY ADMINISTERED NUTRITION:

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Offer food by mouth if feasible and desired.

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 / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s medical condition and preferences.

Print Physician/NP/PA Name: __________________________
Physician/NP/PA Phone #: __________________________
Physician/NP/PA License #, NP Cert. #: __________________________

Signature of Physician/NP/PA Signature: __________________________ Date: __________

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. 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: __________________________ Date: __________

Mailing Address (street/city/state/zip): __________________________ Phone Number: __________________________

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid*
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information
Name (last, first, middle):  Date of Birth:  Gender:  M  F
NP/IPA's Supervising Physician  Preparer Name (if other than signing Physician/NP/PA)
Name:  Name/Title:  Phone #:
Additional Contact  □ None  Relationship to Patient:  Phone #:

Directions for Health Care Provider
Completing POLST
- Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient’s preferences.
- 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/NP/PA 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.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker’s authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- 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 patient who has chosen “Do Not Attempt Resuscitation.”
Section B:
- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort-Focused Treatment,” 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-Focused Treatment.”
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate “Selective Treatment” 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 patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient’s health status, or
- The patient’s treatment preferences change.

Modifying and Voiding POLST
- A patient with capacity can, at any time, request alternative treatment or 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/NP/PA, based on the known desires of the patient or, if unknown, the patient’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 PATIENT WHENEVER TRANSFERRED OR DISCHARGED