**SUMMIT SENIOR LIVING LLC**

**Physician Plan of Care Form**

|  |  |  |
| --- | --- | --- |
| Community Name:  **Summit Senior Living LLC** | Phone Number  **928-227-2329** | Fax:  **928-227-2037** |
| Medical Practitioner Name: | | Phone Number:  Fax: |
| Medical Practitioner Address: | |

|  |
| --- |
| **Diagnosis and Medical Information** |
| Primary (List all): |
| Secondary (List all): |
| Allergies (Medication, food, environmental): |

|  |
| --- |
| **Current Treatments** |
| Treatments: |

|  |
| --- |
| **Diet** |
| Residents are permitted to self-select their meals. Please mark the diet desired for your patient. |
| * Regular diet * NAS (No Salt Added) * No Concentrated Sweets * Mechanical Soft * Finger Foods |

**Medication Administration: Any attachments MUST be signed by Medical Practitioner.**

**Our license allows unlicensed personnel to administer medications for your patient.**

The certified caregivers at this community have my permission to administer medication to my patient as indicated:

Please indicate preference:

* ***May self-administer medications***. Medications may be kept in resident’s room and taken without staff supervision.
* ***Staff administer the medications.*** Medications are stored in central location and administered by staff only.
* ***May keep OTCs in apartment for self-administration.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Current Medications (Routine, PRN, Over-the-Counter)** | | | | | | |
| **Medication** | **Dose** | **Route** | **Frequency** | **PRN (Max Dose)** | **Quantity** | **Refills** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***All medication approved for 30-day supply with 11 refills***

**Communicable Disease Screening:**

\*Mantoux Skin Testing: Inject 0.1 ml (containing 5 turberculin units) via intradermal injection on the forearm upon move in and/or once every year by a licensed nurse per state regulatory requirements

|  |  |
| --- | --- |
| Date of Mantoux TB skin test\* (within past 90 days) | Result |
| Date of last chest x-ray | Result |

***\*If it is medically inappropriate for this person to receive a Mantoux TB skin test, please explain on the back of this document.***

This person [( ) is ( ) is not] free of communicable disease in any known or apparent form.

Current immunization status:

* Pneumococcal Vaccine: Date: \_\_\_\_\_\_\_\_\_\_
* Flu Vaccine: Date: \_\_\_\_\_\_\_\_\_\_
* Covid 19 Vaccine: Date: \_\_\_\_\_\_\_\_\_\_ (1st shot)

Manufacture: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ (2nd shot)

May we administer a flu vaccine annually? ( ) Yes ( ) No

May this person consume alcoholic beverages? ( ) Yes ( ) No

May this person participate in general exercise? ( ) Yes ( ) No\*

\*If no, what are his/her limitations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended physician visit schedule:

( ) Every 3 months ( ) Every 6 months ( ) Annually ( ) Other:

**(Please provider an order under the “Medication” section of this form)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Instructions:** | | | |
| **Treatments** | **No** | **Yes** | **Frequency** |
| Accu-Checks |  |  |  |
| Oxygen |  |  |  |
| Home health (PT, OT, SN) |  |  |  |
| Hospice |  |  |  |
| Lab Work (PT/INR) |  |  |  |
| Other |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Appropriateness for Assisted Living:**

I have examined this patient and my finding are as follows:

* Resident is appropriate for Assisted Living and does not pose an elopement risk nor a threat to themselves or others.
* Resident does not require intermittent nursing services (home health)
* Resident does not require hospice services

**OR**

* Resident is inappropriate for assisted living and requires Secured Memory Care.
* Resident does require intermittent nursing services (home health)
* Resident does require hospice services

**Standing Orders:**

1. Acetaminophen 325 mg, 2 tabs by mouth 4qh PRN Pain/Fever
2. MOM 30cc by mouth daily PRN for constipation
3. Loperamide 2mg, 2 tabs by mouth after first loose stool, 1 tab by mouth for each subsequent episode PRN. Not to exceed 4 tabs in 24 hrs.
4. Calcium Carbonate Tablets, 2 tablets by mouth PRN for heartburn, not to exceed 3 doses in 24 hrs.
5. Antibiotic ointment and dry dressing for skin tears and minor wounds PRN daily.

I have examined the above-named patient and they do not require continuous medical services or nursing services (hospitalization, skilled nursing) and they do not require continual behavior health services or restraints.