IOSCO COUNTY MEDICAL CARE FACILITY
PHYSICIAN'S REFERRAL FOR ADMISSION

Patient Name_____ **Date**_____

The above patient needs care at the Iosco County Medical Care Facility for the following reasons:

CURRENT PROBLEMS

Respiratory

_____TRACH _____N/C MASK
_____OXYGEN _____LITERS
_____SUCTIONING

AMBULATION

_____ INDEPENDENT _____CANE
_____ASSIST _____W/C
_____WALKER _____BEDRIDDEN

Orientation/Mental Status

_____ALERT _____ORIENTED
_____COOPERATIVE _____COMATOSE
_____CONFUSED _____LETHARGIC
_____COMBATIVE _____DELUSIONS
_____AGITATED _____ANXIOUS
_____WANDERING _____HALLUCINATIONS

Speech

_____ADEQUATE _____IMPAIRED
_____GESTURES

ADL'S

_____INDEPENDENT _____ASSISTANCE
_____TOTAL DEPENDENCE ON OTHERS

Current Medications:

Present Diagnoses:

Past Medical History:

SURGERIES:

TUBERCULOSIS:
ALLERGIES:

Elimination

_____CONTINENT _____COLOSTOMY
_____INCONTINENT _____FOLEY
_____INTERMITTENT CATH

SKIN

_____INTACT _____RASH
_____PRESSURE AREAS, IF YES AT WHAT STAGES?
ANY SKIN TREATMENT_____
_____
_____

Hearing

_____ADEQUATE _____HOH R___L___
_____HEARING AID _____R_____L___
_____DEAF

Vision

_____GLASSES _____BLIND

Diagnosis_____
_____

Diet

_____FEEDS SELF _____ NEEDS ASSISTANCE
_____TUBE FEEDING ___N/G ___G/I TUBE
_____TPN OTHER: _____

Current Diet: _____
LAST TETANUS: _____
PNEUMONIA VACCINE GIVEN: _____

FLU VACCINE GIVEN: _____

DO YOU WISH TO CONTINUE TO FOLLOW THIS PATIENT AFTER THEY HAVE BEEN ADMITTED TO THE FACILITY?
___NO ___YES, PLEASE CONTACT THOMAS D. MEYER ADMINISTRATOR FOR A MEDICAL STAFF PRIVILEGES PACKET AT 989-362-4424 EXT. 1015

PHYSICIAN'S SIGNATURE_____ **DATE**_____

PLEASE RETURN TO: ADMITTING DEPT
IOSCO COUNTY MEDICAL CARE FACILITY
1201 HARRIS AVE. TAWAS CITY, MICHIGAN 48763