EVERLASTING
Community Services

PAPERWORK REQUEST

Please complete all pages on the Medical Practitioner's Plan of Care.
Incomplete documents will unfortunately cause a delay in admission.
Admissions occur Monday-Thursday.

[] TB Test needs to say free from PPD, even if it is an X-Ray. Include date.
[] Please include most recent H & P
[] Return documents to Alicia at fax or email below
[] Please include complete medication list AND fax medlist to:

Neighborhood LTC Pharmacy
FAX: 602.688.8016
Phone: 602.396.7330
690 North Cofco Center Court, Ste. 100
Phoenix, AZ 85008

Questions can be directed to:

Alicia M. Brown, ASB LPN
Marketing Director
Everlasting Community Services
Brain Injury Assisted Living
Direct phone: 602.388.1749 x202
FAX: 602.340.1777
alicia@everlastingservices.com

Thank you!

EVERLASTING
Community Services

EVERLASTING SERVICES @ Estrella Center

MEDICAL PRACTITIONER'S PLAN OF CARE: (Move-In Orders)

Resident's Name:	DOB	Date of Visit:
Medical Practitioner's Name:		Phone Number:
Medical Practitioner's Address:		Fax Number: (Medical Provider's office Information)

Diagnosis and Medical Information

Primary Please attach a copy of most recent physical and/or history
Secondary
Allergies

Current Treatments and Diet

Treatments:

Diet: ☐ Regular ☐ Finger Foods ☐ Pureed Diet
☐ Other: ☐ Texture Modification ☐ Known food allergies:

Communicable Disease Screening

Residents must be screened for any communicable disease including tuberculosis. The Infectious Disease Screening includes a Mantoux TB skin test or chest x-ray, (if the resident is known to have a positive reaction to the skin test.) Or the Medical Provider certifies the absence of TB and communicable disease. *ALL Screenings or statements cannot be more than 6 months prior to admission to the Assisted Living Facility.*

Date of Mantoux TB skin test* (within 6 months)	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:

This person: ☐ is ☐ is not free of communicable disease in any apparent form, including TB.

May we administer an annual Mantoux TB skin test?	☐ Yes	☐ No
May we declare this person as 'Do Not Resuscitate'?	☐ Yes	☐ No
May we administer a pneumovax vaccine?	☐ Yes	☐ No
May we administer a flu vaccine annually?	☐ Yes	☐ No

X_____ _____

Medical Practitioner's Signature **Date**

EVERLASTING
Community Services

EVERLASTING SERVICES @ Estrella Center

MEDICAL PRACTITIONER'S PLAN OF CARE: (Move-In Orders)

Resident's Name: DOB:

Instructions Related to Plan of Care:

Level of Care: *Scope of Services Offered:*

I have examined this person and find no evidence to support the need for continuous skilled nursing care, continuous medical services, behavioral health services, or use of restraints (which includes the use of bedrails) at this time. Further, is appropriate for assisted living and does not pose a threat to self or others,

Level of care recommended is:

☐ Supervisory care (supervision only, Independent with ADL's)

☐ Personal care (need assistance to complete most tasks/ADL's) which may include "behavior care services" for TBI (traumatic brain injury) specialized care needs

☐ Directed/ dementia specific care (cannot self-direct care, requires Moderate to total assistance to Complete ADL's may require behavior care planning)

This person currently requires intermittent nursing services such as Hospice or Home Health? ☐ Yes ☐ No

It is medically safe for this person to participate in evacuation drills? ☐ Yes ☐ No

It is not medically necessary to weigh this resident? ☐ Yes ☐ No

If no, resident needs to be weighed? ☐ daily ☐ weekly ☐ monthly ☐ quarterly

May this person consume alcoholic beverages? ☐ Yes ☐ No

May we evaluate for Home Health / PT/OT,ST ? ☐ Yes ☐ No

May this person participate in general exercise? ☐ Yes ☐ No* If no, what are his/her limitations?

Instructions Related to Medications Management:

Our license allows unlicensed personnel to administer medications & treatments to your patient under the direction and written order of the Medical Provider or primary provider. Trained caregivers administer the medications /treatments. We must have a Medical Provider order for **all meds**, including PRN, **over-the-counter** medications, narcotics and any **all treatments.** Please check one:

☐ ***May self-administer medications.*** *Medical Provider must specify medications (time, dose, and route). Medications are kept locked in resident's room and taken without staff supervision.*

☐ ***Staff Assistance with Self-Administration of Medications.*** *Observing the resident while they remove the medication from the container or medication organize,* ***such as: Nitroglycerin tablets, eye drops, & inhalers***

☐ ***Medications Administration.*** *Medications are stored in central location and administered by trained staff only. Includes placing a specific dose into their hand, cup, mouth, or by prescribed route and observing them take*

☐ *May Crush Medications & place in food if needed*

☐ *Staff may fill med-organizer for resident if applicable*

X_____ _____

Medical Practitioner's Signature **Date**

Facility Name: Everlasting Services @ Estrella Center 3100 N. 91st Ave Phoenix, AZ 85037	Phone: 623-934-4411 FAX: 602-340-1777

MEDICAL PRACTITIONER'S PLAN OF CARE: (Move-In Orders)

Resident's Name:	DOB

	Medications Order	Quantity	# of Refills
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
	PRN Medications	Quantity	*# Refills*
1			
2			
3			
4			
5			
6			
7			
8			

_____ _____

x _____ _____

Medical Practitioner's Signature **Date**

EVERLASTING
Community Services

EVERLASTING SERVICES @ ESTRELLA CENTER
ADVANCE DIRECTIVES

RESIDENT'S NAME:_____ **D.O.B.**_____

Sex: [ ] Male [ ] Female Attending Medical Practitioner_____

Person with legal medical capacity to make decision is: [ ] Self/ resident [ ] Legal Guardian
[ ] Spouse [ ] Other (explain)_____

The person(s) identified above have consented to the following treatment plan:

____ 1. **Full Resuscitative Measures:** Emergency measures will be taken to sustain and prolong life. Cardiopulmonary Resuscitation (CPR) in the event of cardiac / pulmonary arrest. Hospital admission may be necessary. (No living will)

____ 2. **A Living Will is on File:** CPR will be done, and paramedics called, Upon arrival to a hospital, family and Medical Practitioner will discuss further Heroic measures.

____ 3. **Do Not Resuscitate (DNR):** In the event of cardiopulmonary arrest, there would be **NO** resuscitation efforts. Therapeutic care will be provided for any other medical conditions and could include Emergency Room treatment and / or hospitalization.
(Requires State of AZ "Prehospital Medical Care Directive" (DNR) copied on ORANGE paper to be completed and signed also)

TO BE COMPLETED BY THE RESIDENT, FAMILY OR PROXY

I have been informed of and understand the care and treatment options offered at "the Facility."

I understand I may revoke these directives at any time. I give permission for this information to be given to Medical Practitioners, nurses, Paramedics, and other health personnel as necessary to implement these directives.

Resident's/Proxy Signature:_____ Date:_____

Relationship to Resident:_____

TO BE COMPLETED BY THE MEDICAL PRACTITIONER:

These directives are the expressed wishes for the resident, guardian and / or family, are medically appropriate and are documented in the resident's medical records.

Medical Practitioner's Signature:_____ Date:_____

Facility Representative:_____ Date:_____

EVERLASTING
Community Services

DIET TERMINOLOGY-DEFINITIONS

RESIDENT MOVE IN

Resident's Name:

Our Facility diets are as described below. **Please, indicate the diet desired for your patient on the move-in orders form attached or circle the appropriate diet, sign and date, and return this form to the Facility.**

Only the following modified diets will be offered:

1. **Regular Diet** – Regular foods that are familiar and traditional to the residents. The regular diet is prepared with very little salt and seasonings containing salt. Herbs and spices are used for flavoring. The regular diet provides approximately 2000 to 2200 calories, 80 to 100 grams of protein. Residents are allowed to add more salt to their food at the table if they desire. In order to keep the sodium level lower, fresh or frozen vegetables are used.
2. **Regular Diet, Large Portions** – This diet can be used for residents with increased nutrient needs or residents with desired extra meal portions. This is the regular diet with 1½ portions. This diet provides approximately 2500 – 2700 calories.
3. **NAS (No Added Salt Diet)** – This diet is used for residents with edema, high blood pressure or mild congestive heart failure. The NAS diet provides approximately 2000 to 2200 calories, 80 to 100 grams or protein and 3 to 4 grams of sodium.
4. **Carbohydrate Controlled Diet** – This diet is used for residents that are diabetic (both insulin dependent and non-insulin dependent) or residents who desire weight loss or weight maintenance. This diet follows the new diabetic guidelines that are endorsed by the American Diabetes Association and the American Dietetic Association. These guidelines encourage controlling carbohydrates versus prescribing calorie-level diet plans. This diet provides approximately 1800 - 2000 calories with 50-60% of calories from carbohydrates.
5. **Regular Diet, Texture Modifications for Meat** *(specify cut-up, chopped, ground, etc.)* Texture modifications can include cut up meat into bite size pieces, chopped meat, ground meat, and thickened liquids. All other foods such as salads and fresh fruits and vegetables can be served minced, cooked, or canned as tolerated by the resident. Specify whether the resident requires thickened liquids.
6. **Pureed Diet** – All foods will be pureed to the consistency of mashed potatoes or pudding unless otherwise specified. Depending on the natural water content of the food, some type of nutritive liquid such as milk, broth or juice may need to be added to puree the food. Some pureed foods will be served in formed shapes to resemble the original food item.
7. **Finger Foods** – This menu is designed for residents who have difficulty using utensils to eat or decreased hand dexterity. With this menu, the regular diet is adapted to provide the same foods but in a form that is easy to pick up with the fingers and allow (or encourage) more self feeding.
8. **Small portions** may be provided for any of the diets listed above for resident weight loss or weight maintenance. The resident will receive ¾ of the normal portion. The nutritional values are adjusted accordingly.

Medical Practitioner's Signature: _____ **Date:** _____

EVERLASTING
Community Services

EVERLASTING SERVICES **Determination Statement**

Resident's Name:	Apt #
Reason for Request: [ ] Confined to bed or chair staff must assistance [ ] Has stage 3 or 4 Pressure sore [ ] Requires Behavioral Care (please review & sign behavior care consent q 6months)	
Type of Request: [ ] Accept/Move-in [ ] To Continue to Retain (change of condition) **Date of onset:**	

This is a request for Continued Residency for the above-named resident. Family and/or resident wish to reside or continue to reside at Everlasting Services, a licensed assisted living facility. Our scope of services includes Supervisory, Personal Care and Directed Care Services.

All of the following criteria must be met in order for your patient to reside or continue to reside at Our Facility in accordance to Assisted Living State Regulations.

Medical Practitioner's Name:_____

- ☐ Primary care provider has examined patient in last 30 days
- ☐ Primary care provider agrees to examine patient every 6 months during the duration of the condition and to update the request for continued residency agreement.
- ☐ Agrees facility is able to meet needs and will document services provided in the facility's resident records
- ☐ I have examined this person and find no evidence to support the need for continuous skilled nursing care, continuous medical services behavioral health services, or use of restraints at this time. Further is appropriate for assisted living and does not pose a threat to self or others
- ☐ Intermittent nursing services such as home health or hospice may be used to support care needs

All parties agree to the above provisions that the resident's needs can be met by Everlasting Services within the scope of services provided by the facility.

_____ _____
Resident or responsible party Date

_____ _____
Medical Practitioner/ primary care provider Date

_____ _____
Facility Representative Date

CONSENT FORM - FOR NON-AMBULATORY SERVICES

RESIDENT'S NAME:_____

***** MUST BE SIGNED EVERY 6 MONTHS BY THE MEDICAL PRACTITIONER OR BEHAVIORAL HEALTH PROFESSIONAL, PER ARIZONA STATE REGULATIONS*****

As a non-ambulatory resident living at Everlasting Services,_____
(name)

who requires assistance with transferring and ADL assistance . The coordination and care for this person can be adequately achieved while residing at Everlasting Services, an assisted living facility that specializes in brain injury care.

_____ _____
Medical Practitioner 's Signature Date

_____ _____
Responsible Party's Signature Date

CONSENT FORM - FOR BEHAVIORAL CARE SERVICES

RESIDENT'S NAME:_____

***** MUST BE SIGNED EVERY 6 MONTHS BY THE MEDICAL PRACTITIONER OR BEHAVIORAL HEALTH PROFESSIONAL, PER ARIZONA STATE REGULATIONS*****

The Scope of Services for the resident,_____, will be adequately
(name)
provided by Everlasting Services for behavioral care services and supervision in their assisted living facility. Everlasting Services is a licensed care facility in Arizona that specializes in brain injury care and services.

_____ _____
Medical Practitioner's or Behavioral Health Professional Signature Date

PREHOSPITAL MEDICAL CARE DIRECTIVE
(DO NOT RESUSCITATE or DNR)

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

PREHOSPITAL MEDICAL CARE DIRECTIVE

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

***If I am unable to communicate my wishes, and I have designated a Health Care Power of Attorney, my elected Health Care agent shall sign:**

Health Care Power of Attorney Printed Name: _____

Health Care Power of Attorney Signature: _____

PROVIDE THE FOLLOWING INFORMATION OR ATTACH A RECENT PHOTO:

Date of Birth_____
Sex_____
Race_____
Eye Color _____
Hair Color _____

INFORMATION ABOUT MY DOCTOR AND HOSPICE (if I am in Hospice):

Physician:_____ Telephone: _____
Hospice Program, if applicable (name):_____

SIGNATURE OF DOCTOR OR OTHER HEALTH CARE PROVIDER

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: _____
Date: _____

SIGNATURE OF WITNESS OR NOTARY (NOT BOTH)

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Witness Signature:_____ Date: _____

NOTORIAL JURAT:

STATE OF ARIZONA) ss
COUNTY OF _____)

_____
Patient's Name/Health Care Power of Attorney Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____ My Commission Expires: _____