## **Physician Move In/Return From Hospitalization Orders**

Resident's Name:	ame: Date of Physician Visit:								
Physician									
Address									
Phone	Fax Number (Please attach a copy of most recent physical and/or history)								
	(Please attac	h a copy of most i	recent physic	al and/or histo	ory)				
Diagnosis									
Primary:									
Allergies:									
Obtain the following e	valuations and	I follow approved	Plan of Care	as recommen	ded by specia	alty.			
	PT			RESPIRAT	ORY				
	ОТ			MENTAL F	IEALTH				
	SPEECH			☐ HOME HEALTH					
May have podiatry se  Immunizations	rvices provided	d at community:	☐ Yes		No				
Pnemovax May have Annual Influ		0.5cc IM		Yes  Yes	No No				
Medication Admini	stration								
☐ Self-Admini			Assistance	☐ Me	edication Admi	inistration			
Current Medications  Medicati		N, OTC):  Dose	From		Quantity	Refills			
iviedicati	OII	Dose	Freq	uency	Quantity	Reillis			
Physician Signature				Date					

Resider	nt		Physicia	an			Date		
	Notify me each t	ime the reside	nt refuses	s medications	or treatm	ents			
	Do not notify me if this resident refuses any medications or treatments with the following exceptions:								
	equivalents may			•		Yes		No	
	edications and tread d staff after evalua		sed for 90	days may be	discontir	ued at th Yes	ne discreti	on of the No	
Current	Treatments:								
Recon	nmended Diet:			Food	Allergies	3			
them to be provi	nts living at this co maintain their ow ided. Please indic	n diet and are cate if this resid	restricted dent shou	only by their all only by their all only by	own sele of these:	ctions. T	he followi	ng diets may	
Liquids:	Т	- hin		Honey Thicke	ned		Nectar T	hickened	
May the	e resident have ald	ohol on specia	al occasio	ons?	⊃ Yes		No		
Signatu	ıres								
Nurse R	Reviewing				Da	ate/Time:			
	an Signature								
DOW R						ate/Time:			

WELL 60.9213 04/18