BAYSHIRE TORREY PINES SENIOR LIVING

Physician Report and Admission Orders

FACILITY INFORMATION

NAME OF FACILITY:	**Bayshire Torrey Pines**	FACILITY LICENSE #:	37460317
ADDRESS:	13101 Hartfield Ave San Diego, Ca 92130		
TELEPHONE:	(858) 259-2222	FAX NUMBER:	858-259-2211

RESIDENT / PATIENT INFORMATION

RESIDENT NAME: BIRTH DATE: AGE:

I hereby authorize the release of medical information contained in this report to the facility named above.

NAME & SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE:

DATE:

RESIDENT / PATIENT DIAGNOSIS

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of an assisted living facility. 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.)

DATE OF EXAM: SEX: HEIGHT: WEIGHT: BLOOD PRESSURE:

TUBERCULOSIS (TB) TEST

DATE TEST OR CHEST X-RAY COMPLETED: RESULT: ☐ Active TB Disease ☐ Latent TB Infection ☐ No evidence of TB infection or disease

DIAGNOSES - List all diagnoses, including primary and secondary if applicable.

INFECTIOUS / CONTAGIOUS DISEASE

☐ No ☐ Yes – Describe and indicate precautions required:

ALLERGIES

☐ No ☐ Yes – Describe:

PHYSICAL AND FUNCTIONAL HEALTH STATUS

	Yes	No	Unknown	Comments / Assistive Devices, If Applicable:
Auditory Impairment				
Visual Impairment				
Wears Dentures				
Wears Prosthesis				
Substance Abuse Problem				
Alcohol Restrictions				
Cigarette/Smoking/Vaping Restrictions				
Bowel Impairment				
Bladder Impairment				
Motor Impairment / Paralysis				
Requires Continuous Bed Care				
History of Or Current Skin Breakdown/Condition				
Able to bathe self				
Able to groom / dress self				
Able to feed self				
Able to care for own toileting needs				

DIET

☐ Regular diet ☐ No concentrated sweets ☐ No added salt ☐ Finger foods ☐ Meals to be cut up prior to serving

☐ Thickened liquids ☐ Mechanical soft ☐ Pureed ☐ Reduced fat

MEDICATION MANAGEMENT

Able to manage and store own medications: ☐ Yes ☐ No

Able to administer own medications: ☐ Yes ☐ No

Able to administer own injections: ☐ Yes ☐ No ☐ N/A

Able to perform own glucose testing: ☐ Yes ☐ No ☐ N/A

Able to administer own oxygen: ☐ Yes ☐ No ☐ N/A

Regarding PRN medications, check **ONE** of the following:

☐ Able to determine need and communicate need clearly for PRN medication

☐ Able to communicate symptoms clearly but cannot determine need for PRN medication

☐ Unable to determine need or communicate symptoms clearly for PRN medication

END OF LIFE CARE PLANNING

Is there a POLST in place? ☐ Yes ☐ No

Is there an Advanced Directive in place? ☐ Yes ☐ No

Is resident receiving hospice care? ☐ Yes ☐ No If yes, specify terminal diagnosis:

AMBULATORY STATUS

This person is able to independently transfer to and from bed: ☐ Yes ☐ No

For purposes of 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.

If a resident is nonambulatory, this is based upon: ☐ Physical condition ☐ Mental condition ☐ Both physical and mental condition

BEDRIDDEN STATUS

If the person is Bedridden, check one or more of the following and describe the nature of the illness, injury, surgery or other cause:

☐ Illness:

☐ Recovery from surgery:

☐ Other:

If the person is bedridden, how long is bedridden status expected to persist (number of days)?

MENTAL / COGNITIVE CONDITION

	Yes	No	Unknown	Comments:
Mild Cognitive Impairment				
Dementia				
Confused / Disoriented				
Able to Follow Instructions				
Able to Communicate Needs				
Inappropriate Behavior				
Aggressive Behavior				
Wandering Behavior				
Sundowning Behavior				
Depressed				
Suicidal / Self-Abuse				

FOR A RESIDENT WITH A DEMENTIA DIAGNOSIS

At risk if allowed direct access to personal grooming & hygiene items: ☐ Yes ☐ No ☐ N/A

At risk if allowed to leave the community unsupervised due to dementia or cognitive decline: ☐ Yes ☐ No ☐ N/A

COMMENTS

MEDICATIONS / TREATMENTS

Please list all current medication / treatments below or attach a SIGNED medication list. Pharmaceutical equivalents or therapeutic equivalents are approved for all medications listed on this form approved unless otherwise specified.

Medication / Strength	Dose / Route / Frequency	Diagnosis / Reason	Qty	# Refills

ADDITIONAL ORDERS

Influenza vaccine, annually	☐ Yes	☐ No		Pneumococcal vaccine, annually	☐ Yes	☐ No	
TB skin test 2-step PPD, as needed	☐ Yes	☐ No		COVID-19 testing, as needed	☐ Yes	☐ No	
Therapy home evaluation	☐ PT	☐ OT	☐ ST	First aid and dressings for minor cuts or skin tears	☐ Yes	☐ No	
Medications must be crushed	☐ Yes	☐ No					

PHYSICIAN SIGNATURE AND ADDRESS

I have examined the above-named resident who is my patient. I have reviewed the orders included in the Admission Orders and Physical Examination form and approved of the above orders for the resident named. These orders will be in effect until such time as they are discontinued by myself or another authorized prescriber.

PHYSICIAN'S NAME:

ADDRESS:

TELEPHONE:

SIGNATURE (Electronic Signature Acceptable): DATE:

Admission Orders (California)

Resident:	Age:	DOB:	Expected Date of Admission:

GENERAL ORDERS		Comments/Instructions
Resident is capable of self-administering medications?	☐ yes ☐ no	
Resident is permitted to consume alcohol?	☐ yes ☐ no	
Resident's current medications require crushing? If yes, list.	☐ yes ☐ no	
Does the resident require a special diet? If yes, please describe.	☐ yes ☐ no	
DNR Status		

ROUTINE MEDICATIONS

Medication/Strength	Dose/Route/Frequency	Qty	# Refills

PRN MEDICATIONS

Please initial next to the statement that best describes this resident:

	My patient can determine and clearly communicate his/her need for prescription and nonprescription PRN medication.
	My patient cannot determine his/her own need for a nonprescription PRN medication, but can communicate his/her symptoms clearly indicating a need for a nonprescription medication.
	My patient cannot determine his/her need for prescription or nonprescription PRN medication and cannot communicate his/her symptoms clearly indicating a need for a prescription or nonprescription medication. (Must contact physician before each dose is given and receive instructions.)

Medication/Strength	Dose/Route/Frequency	Symptom/Reason	Max Dose in 24°	Qty	# Refills

Signature/Title:_____ Date: _____

Print Name (prescriber): _____ DEA #: _____

BAYSHIRE SENIOR COMMUNITIES

Resident Name: _____

STANDING ORDERS **The following are standing orders that we would like to institute for your patient.** **Please line out any orders that you do not approve of for your patient.**	
	Instructions (please complete if blank)
Influenza vaccination	Annually
Pneumococcal vaccine	
Minor cuts/abrasions	1) Clean with shur-clens (or soap and warm water), pat dry, 2) apply antibiotic ointment, 3) cover with band-aid dressing, 4) change daily as needed, 5) observe daily for signs and symptoms of infection: increased redness, swelling, pain, drainage or temperature. 6) If resident experiences any of these symptoms notify MD. 7) Discontinue when healed.
Minor skin tears	1) Wash with shur-clens (or soap and warm water). 2) Apply non-stick dressing and steri-strips, change as needed. 3) Allow steri-strips to remain in place until they fall off. 4) Observe daily for signs and symptoms of infection: increased redness, swelling, pain, drainage or temperature. 6) If resident experiences any of these symptoms notify MD. 7) Discontinue when healed.

Medication	**Dose/Route/Frequency/Symptom/Reason**	**Qty**	**# Refills**
Tylenol, 325 mg	po 2 tabs every 4 hours prn for fever over 100 degrees not to exceed 6 tablets in a 24 hour period		
Tylenol, 325 mg	po 2 tabs every 4 hours prn for pain not to exceed 6 tablets in a 24 hour period		
Imodium AD, 2 mg	po for diarrhea, 2 caps initially, then 1 cap after each loose stool until diarrhea is controlled, but not to exceed more than 4 caplets in 24 hours.		
Mylanta (regular strength)	po 4 teaspoons (20 ml/cc) every 4 hours prn for stomach upset not to exceed 24 teaspoons (120 ml/cc) in 24 hours. Notify MD if persists over 48 hours.		
Milk of Magnesia	po 2 tablespoons (30 ml/cc) everyday prn for constipation not to exceed 2 tablespoons (30 ml/cc) in 24 hours. Encourage a full glass (8 oz.) of liquid with each dose.		

If you approved of the above orders for the resident named, please sign below. If you do not approve of any of the orders, please line out the order. These orders will be in effect until such time as they are discontinued by yourself or another authorized prescriber. Thank you for your time and cooperation.

Please print name (prescriber):	**Date:**
Signature/Title:	
DEA #:	

BAYSHIRE SENIOR COMMUNITIES

PRN AUTHORIZATION LETTER

Date: _____

Dear: Dr. _____ Fax Number: _____

Re: Your Patient: _____

A resident of (Community): **Bayshire Torrey Pines**

To receive nonprescription and prescription PRN medications, state licensing requires that either:

1) your patient be capable of determining their own need for medication, or
2) for non-prescription medication only, be able to clearly communicate their symptoms.

If your patient cannot determine their need for a medication or clearly communicate the symptoms for a nonprescription medication then you, the physician, must be contacted before the PRN medication can be given. Your completion of this form will serve to document your patient's current ability to determine their own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine their own need for PRN medications and inform you of any changes which indicate he/she can no longer make these decisions.

Thank you for your assistance.

Signature: _____ Title: _____

Telephone No.: _____ Fax No.: _____

Please check which circumstance describes your patient:

- ❑ My patient can determine and clearly communicate their need for prescription and nonprescription medication on a PRN basis.
- ❑ My patient cannot determine their own need for a nonprescription PRN medication but can communicate their symptoms clearly indicating a need for a nonprescription medication.
- ❑ My patient cannot determine their need for prescription or nonprescription PRN medication and cannot communicate their symptoms indicating a need for a prescription or nonprescription medication. Community staff must contact the resident's physician before each dose is given and receive instructions.

The following prescription and nonprescription medications can be taken on a PRN basis:

_____ _____ _____

_____ _____ _____

Physician's Signature: _____ Date: _____

BAYSHIRE SENIOR COMMUNITIES

What is a POLST?

Key Facts About POLST for Individuals and Family Members

Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.

- **POLST is for people who are seriously ill or have advanced frailty**. If you are healthy, an advance directive is for you.

- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.

- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.

- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician, nurse practitioner, or physician assistant.**

- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST**. Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.

- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.

- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.

- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

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.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **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: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **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: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

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/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		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: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
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/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	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

Dietary Orders

Resident: _____ **Apt #:** _____

Effective Date: _____

- ❑ New Move-in
- ❑ Change

Resident Requires:

- ❑ Regular Diet
- ❑ NCS (controlled carbohydrate)
- ❑ NAS (approximately 4-6 grams sodium)
- ❑ Finger Foods
- ❑ Meals to be cut up prior to serving
- ❑ Mechanical Soft
- ❑ Pureed
- ❑ Reduced Fat
- ❑ Thickened Liquids

Resident is:

- ❑ Diabetic
- ❑ Lactose Intolerant (no dairy products)
- ❑ Vegetarian
- ❑ Allergic to: _____

_____

Special Needs:

_____

_____

_____

_____

Date: _____

_____
Physician Signature

_____
Physician Name

_____
Physician Phone #

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