Parts 1-3 White Yellow Pink

ADMISSION ORDERS

SECTION A: MEDICATION/TREATMENT	SECTION D: OTHER (Complete this section once part 4 is detached)	
	Admit to:	
Diameter.	Rehab potential: O Good O Fair O Poor O None LOC: O Skilled O Nursing O Oth	er
Diagnosis:	Comment:	
	CPR Status: O No CPR O Yes CPR Resident Representative aware: O No	O Yes
	Advance Directives: O No O Yes Copy attached: O No O Yes	
Diagnosis:	Diet Order:	
	Texture: O Regular O Ground meat O Pureed O As tolerated O Other	
	☐ May have regular diet - special occasions ☐ Supplements:	
Diagnosis:	Therapy Evaluation Orders:	
Diagnosis.	Weight bearing: ☐ Full ☐ Partial ☐ None Mobility Status:	
	PT x per week OT x per week ST x per week	
	-500 April 100 April	YES NO
Diagnosis:	Restraints – If yes, type/frequency/reason	0 0
	Bed/side rails - If yes, type/frequency/reason	0 0
	Podiatry care PRN	0 0
Diagnosis:	Dental care PRN	0 0
	Ophthalmology care PRN	0 0
	Audiology care PRN	0 0
	May participate in: Overall activity plan	0 0
Diagnosis:	Volunteer program //	0 0
	May have occasional alcoholic beverages	0 0
2017 P.S.	May go on pass with meds	0 0
Diagnosis:	TB screening per facility policy	0 0
	Chest X-ray	0 0
	Pneumococcal vaccine	0 0
Diamenti.	Influenza vaccine	0 0
Diagnosis:	Laboratory orders (specify below, including frequency)	0 0
		0 0
		0 0
Diagnosis:		0 0
		0 0
	Vital signs per facility policy	0 0
Diagnosis:	Weight per facility policy	0 0
Diagnosis.	Docidata Disabayaa Dlani	
	Resident Discharge Plan: SECTION D: PHYSICIAN VISITS/PLAN OF CARE	
	I will visit resident at least once every 30 days for the first 90 days after admission, then at	loast once
Diagnosis:	every 60 days thereafter. I have reviewed this resident's plan of care and am in agreement	with it.
ORDERS VERIFIED AND NOTED	Physician	O AN
O AM at O PM Date	Signature Date Time	
Nurse	Administra Deta	
Signature/Title GENERIC EQUIVALENTS MAY	Admission Date Date of Birth BE USED SECTION C: ALLERGIES No Known Allergies	
SECTION B: ADDITIONAL DIAGNOSES	SECTION C: ALLERGIES UNO Known Allergies	
SECTION B. ADDITIONAL DIAGNOSES	Food	
	Drugs	
	Environmental	
	Other	
WHITE-To Physician for Signature YELL	OW-Temporary Chart Copy PINK-Pharmacy Copy GREEN-Medication Adm.	Record
NAME-Last First	Middle Attending Physician Record No. Room/Bed	

ADMISSION ORDE																													
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SECTION B: ADDITIONAL D																													
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INSTRUCTIONS FOR NURSES MEDICATION NOTES

- 1. State reason and result for PRN medications
- 2. Indicate injection site code
- 3. Indicate ineffective or effective for PRN medications

	INJECTION SITE CODES											
1	Right Dorsal Gluteus	5	Right Lateral Thigh	9	Right Upper Arm							
2	Left Dorsal Gluteus	6	Left Lateral Thigh	10	Left Upper Arm							
3	Right Ventral Gluteus	7	Right Deltoid	11	Right Anterior Thigh							
4	Left Ventral Gluteus	8	Left Deltoid	12	Left Anterior Thigh							

INITIALS	NURSE SIGNATURE	INITIALS	NURSE SIGNATURE	INITIALS	NURSE SIGNATURE

		NURSES MEDICATION NOTES		
DATE TIME MEDICATION &	DOSAGE SITE	REASON	RESULTS OR RESPONSE	NURSE SIGNATURE/TITLE
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