



PHYSICIAN ORDERS AND TRANSFER OF CARE FORM

- Affinity Medical Center
Summa Akron City Hospital
Akron Children's Hospital
Akron General Medical Center
Aultman Hospital
Acute Care Specialty Hospital at Aultman, LLC
Summa Barberton Hospital
Edwin Shaw Rehab
Lodi Community Hospital
Medina Hospital-A Cleveland Clinic Hospital
Mercy Medical Center
Regency Hospital - Barberton
Regency Hospital - Ravenna
Robinson Memorial Hospital
Summa Saint Thomas Hospital
Select Specialty Hospital-Akron
Select Specialty Hospital - Canton
Summa Wadsworth Rittman Hospital
Summa Western Reserve Hospital



ACCESS FORM AT WWW.ARHA.ORG

POST-ACUTE PHYSICIAN ORDERS

MEDICAL INFORMATION

Primary Diagnosis
Secondary Diagnosis

SUMMARY OF PRESENT ILLNESS/SIGNIFICANT TESTS, TREATMENTS, AND PROCEDURES - INCLUDE SURGERIES AND DATES:

Prognosis [ ] GOOD [ ] FAIR [ ] POOR
Patient Aware [ ] YES [ ] NO Responsible Party Aware YES [ ] NO [ ]

REHABILITATION POTENTIAL (REQUIRED FOR ADMISSION) [ ] GOOD [ ] FAIR [ ] POOR
HISTORY AND PHYSICAL (MUST BE WITHIN 5 DAYS OF DISCHARGE)
[ ] YES [ ] NO (If No, Please Update)

DIET AND NUTRITIONAL NEEDS

[ ] Diet [ ] Hyperalimentation
[ ] Tube Feedings [ ] Supplements

ALLERGIES (LIST):

DNR: TRANSFERRING FACILITY (ATTACH COPY)

[ ] YES [ ] NO
DNR STATUS [ ] CC [ ] CCARREST [ ] OTHER DNR

DISCHARGE MEDICATIONS
See Med List [ ]

DOSE/FREQUENCY/ROUTE

PLEASE COPY THIS FORM ONTO YELLOW PAPER

SPECIAL CARE ORDERS

[ ] O2 LITER FLOW:
[ ] IV CARE/PICC Date:
Length: Site: Verified by X-ray [ ] YES [ ] NO
[ ] WOUND CARE/DRESSING CHANGES

[ ] SUCTION
[ ] RESPIRATORY CARE
[ ] VENTILATOR/SETTINGS

Mode [ ] TV [ ] FIO2 [ ] PSV [ ] Peep [ ]
[ ] Additional Orders - includes Tubes, Foley, IVs

LAB WORK

THERAPIES

[ ] PT [ ] OT [ ] ST [ ] RT

ACTIVITY/WEIGHT BEARING (WB)

[ ] UP AD LIB [ ] UP WITH ASSIST
[ ] BED REST [ ] HOB UP 30 DEGREES
[ ] WB AS TOLERATED [ ] NON-WB
[ ] TOE TOUCH - WB [ ] PARTIAL - WB
[ ] ASSISTIVE DEVICES
[ ] Cane [ ] Walker [ ] Wheelchair [ ] Crutches
[ ] Follow up Appointments:

PHYSICIAN INFORMATION

To the best of my knowledge, all information provided is true and accurate.

I certify that in-patient care is required at a level of:

[ ] LT ACUTE CARE [ ] ACUTE REHAB [ ] SNF [ ] ICF
[ ] ASSISTED LIVING [ ] HOME CARE [ ] HOSPICE CARE
and approve of the plan of care and discharge path.

Physician Signature Date Time

Print Physician Name
Physician will follow: [ ] YES [ ] NO

Discharge Date from Hospital
Attending Physician Name
Phone Pager

[ ] See Attached for Additional Orders
[ ] Paperwork attached for tests:

[ ] CONTACT PRIMARY CARE PHYSICIAN (PCP) REGARDING:

Post-Acute to send discharge summary to PCP:
PCP Name:
PCP Phone:



**DEMOGRAPHICS ON PATIENT**

**PATIENT INFORMATION**

TRANSFERRED TO FACILITY/AGENCY \_\_\_\_\_

PATIENT'S NAME TELEPHONE: \_\_\_\_\_  
 LAST: FIRST: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY STATE ZIP CODE \_\_\_\_\_

AGE BIRTHDATE SEX MARITAL STATUS  
 M  F  M  S  D  W

SOCIAL SECURITY # MEDICARE # MEDICAID # \_\_\_\_\_

OTHER INSURANCE INS # AUTH # \_\_\_\_\_

IN PATIENT FROM TO \_\_\_\_\_  
 HOSPITAL ADMISSION DATES

PREVIOUS LIVING ARRANGEMENTS  
 Lives Alone  Hospice  
 Family  Home/ Home Care  
 Home with Care Giver  Passport/Waiver

AGENCY # \_\_\_\_\_

PRIMARY CONTACT \_\_\_\_\_  
 DPOA/HC  
 DPOA  
 Legal Guardian  
 RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY STATE ZIP CODE \_\_\_\_\_

HOME PHONE WORK CELL PHONE \_\_\_\_\_

SECONDARY CONTACT/NEXT OF KIIN  
 NAME PHONE \_\_\_\_\_

WHO WAS NOTIFIED OF TRANSFER? \_\_\_\_\_

TREATMENT RECEIVED WITHIN LAST 14 DAYS	DATE LAST RECEIVED
Chemotherapy <input type="checkbox"/> YES	
Dialysis <input type="checkbox"/> YES	
IV Medications <input type="checkbox"/> YES	
Oxygen therapy <input type="checkbox"/> YES	
Transfusions <input type="checkbox"/> YES	
Radiation <input type="checkbox"/> YES	
Ventilator <input type="checkbox"/> YES	
Tracheotomy Care <input type="checkbox"/> YES	
Suctioning <input type="checkbox"/> YES	
Pneumonia Vaccine <input type="checkbox"/> YES	
Flu Vaccine <input type="checkbox"/> YES	
Mantoux <input type="checkbox"/> YES	
Vital Signs Range: _____	
Last Blood Sugar Result: _____	
Date: _____	
Last Pulse Ox (SaO2) Result: _____	
Date: _____	

**PAIN ASSESSMENT**

None  Acute  Chronic  Intermittent  Sharp  Dull  
 Other (explain) \_\_\_\_\_

LOCATION: \_\_\_\_\_

INTENSITY (1 - 10) \_\_\_\_\_

**ISOLATION**

MRSA  VRE  ACINETOBACTER  CDIFF  ESBL

Site: \_\_\_\_\_

Other Instructions: \_\_\_\_\_

**PERSONAL POSSESSIONS SENT WITH PATIENT ON DAY OF TRANSFER**

Glasses  Purse/ Wallet   
 Dentures/ Partials  Medications   
 Hearing Aid  Walker/ Cane  
 Other \_\_\_\_\_

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

SW/ Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Unit Phone Number: \_\_\_\_\_

**Activities of Daily Living**

Activity	Independent	Supervision	Assist/ # Persons	Unable to Do
Turns Self				
Sits				
Bed to Wheelchair				
Transfers				
Ambulation				
Bathing				
Feeding				
Dressing				
Dental Care				
Bedpan				
Bathroom				
Bedside Commode				

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE \_\_\_\_\_

**CONTINENT BLADDER**  YES  NO  
 CATHETER SIZE \_\_\_\_\_ TYPE \_\_\_\_\_  
 SUPRAPUBIC SIZE \_\_\_\_\_ TYPE \_\_\_\_\_  
 DATE INSERTED/ CHANGED \_\_\_\_\_

**CONTINENT BOWEL**  YES  NO LAST BM \_\_\_\_\_  
 OSTOMY - TYPE \_\_\_\_\_ DATE CHANGED \_\_\_\_\_  
 APPLIANCE \_\_\_\_\_

APPETITE/ NUTRITIONAL	DISABILITIES
<input type="checkbox"/> GOOD	<input type="checkbox"/> AMPUTATION
<input type="checkbox"/> FAIR	<input type="checkbox"/> PROSTHESIS
<input type="checkbox"/> POOR	<input type="checkbox"/> PARALYSIS
<input type="checkbox"/> HYPERALIMENTATION	<input type="checkbox"/> PARESIS
<input type="checkbox"/> FEEDING TUBE	<input type="checkbox"/> CONTRACTURES

MENTAL STATUS	BEHAVIOR
<input type="checkbox"/> ALERT	<input type="checkbox"/> COOPERATIVE
<input type="checkbox"/> ORIENTED	<input type="checkbox"/> BELLIGERENT
<input type="checkbox"/> DISORIENTED	<input type="checkbox"/> COMBATIVE
<input type="checkbox"/> FORGETFUL	<input type="checkbox"/> NOISY
<input type="checkbox"/> UNRESPONSIVE	<input type="checkbox"/> ABUSIVE
<input type="checkbox"/> DEPRESSED	<input type="checkbox"/> PASSIVE

**SAFETY**

RESTRAINTS  HIGH RISK FOR FALLS  
 SITTER  WANDERS

**SENSORY IMPAIRMENTS**

VISION  ADEQUATE  POOR  BLIND  
 HEARING  ADEQUATE  POOR  DEAF  
 HEARING AID  L  R  
 SPEECH  CLEAR  DIFFICULT  APHASIA  
 SPEAKS ENGLISH  
 INTERPRETER REQUIRED

**SKIN CARE**

SKIN INTACT?  Y  N  
 DESCRIBE DECUBITUS/ WOUND - SIZE [CMs], SITE, DRAINAGE \_\_\_\_\_

**ADVANCE DIRECTIVES [ATTACH COPY]**

LIVING WILL  YES  NO  
 DURABLE POWER OF ATTORNEY/HC  YES  NO

SMOKING CESSATION ADDRESSED  YES  NON-SMOKER

**AKRON REGIONAL HOSPITAL ASSOCIATION****PHYSICIAN ORDERS AND TRANSFER OF CARE FORM****COPY AND SEND TO THE NURSING FACILITY IN THE ORDER LISTED**

<b>Chart Form</b>	<b>Content Needed for Admission</b>	<b>Check Off</b>
Post Acute Skilled Transfer Form	Make sure the secondary payer source area is completed	
MARs	Include the most recent MAR and MARs that have the last dose of an IV med, injections or any chemo (IV or PO). Documentation of blood transfusions	
PT, OT, Speech & Respiratory Therapy	Include the evaluation and notes for last week of stay	
Nutrition Evaluation Form		
Medications	If not individually listed on form, attach computerized listing (Medication Reconciliation Form)	
DNR Order Sheet	Either the state form or the hospital form if applicable	
Advanced Directives	Copies of Living Will and/or Durable Power of Attorney for Health Care if on chart	
Physician's Progress Notes	Notes from last 3-4 days	
Nurse's notes/Social Work Notes	Notes from last 2 days; include discharge planning notes; notes including detail on PICC line insertion	
Consultations	A copy of each consult	
Laboratory Results	Most recent labs, including U/A, C&S, CBC, electrolytes, labs used to track dosing of meds (ex; Theophylline/Dilantin level, INRs), MANTOUX	
CXR, EKG	Include most recent	
Cookie Swallow, MRIs, CT Scans	If done, most recent	
H&P and Nursing Assessment with home med sheet	If H&P is dated prior to 5 days before discharge, physician must review, sign, and date	
PASARR ID	Completed Form & results	