AKRON REGIONAL HOSPITAL ASSOCIATION

PHYSICIAN ORDERS AND TRANSFER OF CARE FORM

REVISED 3-1-17

- ☐ Affinity Medical Center
- ☐ Aultman Hospital
- ☐ Aultman Specialty Hospital
- ☐ Cleveland Clinic Akron General
- ☐ Cleveland Clinic Akron General Edwin Shaw Rehab
- ☐ Cleveland Clinic Akron General Lodi Hospital
- ☐ Cleveland Clinic Medina Hospital
- ☐ Crystal Clinic Orthopaedic Ctr.
- ☐ Mercy Medical Center
- ☐ Select Specialty Hospital-Akron
- ☐ Select Specialty Hospital - Canton
- ☐ Summa Akron City Hospital
- ☐ Summa Barberton Hospital
- ☐ Summa Rehab Hospital
- ☐ U.H. Portage Medical Center
- ☐ 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

MEDICATIONS

Discharge Medications	☐ See Med List
All pages of Medication Reconciliation Form are signed & dated	☐ Yes ☐ No
Handwritten script done for all controlled substances	☐ Yes ☐ No
Patient currently on antibiotics? Reason:________________________________	☐ Yes ☐ No Stop Date:________________________

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:________ F102:________ PSV:________ Peep:________

☐ Additional Orders: Includes Tubes, Foley, IVs

LAB WORK

PLEASE COPY THIS FORM ONTO YELLOW PAPER

THERAPIES

☐ PT ☐ OT ☐ ST ☐ RT ☐ RN

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 ORDERS

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:________________________________

PATIENT'S NAME
LAST: ______________________ **FIRST:** ______________________

PHYSICIAN ORDERS CONTINUED

Date: ____________ **Time:** ____________

Physician Name [Print]: ______________________ **Date:** ______________________

Physician Signature: ______________________ **Phone/Pager:** ______________________

OTHER INFORMATION

Name [Print]: **Date:**

Signature: **Phone/Pager:**

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	☐ YES	
Dialysis	☐ YES	
IV Medications	☐ YES	
Oxygen therapy	☐ YES	
Transfusions	☐ YES	
Radiation	☐ YES	
Ventilator	☐ YES	
Tracheotomy Care	☐ YES	
Suctioning	☐ YES	
Pneumonia Vaccine	☐ YES	
Flu Vaccine	**SEE INFLUENZA SECTION BELOW**	
Mantoux	☐ YES	
Vital Signs	Range:	
Last Blood Sugar Date:	Result:	
Last Pulse Ox (Sa02) Date:	Result:	

INFLUENZA INFORMATION

Patient received influenza vaccine in this facility for this year's influenza season ☐ Yes ☐ No
If yes, date influenza vaccine received: ____/____/____
If no influenza vaccine received, state reason:
☐ Pt. not in facility during flu season ☐ Received outside of this facility
☐ Not eligible–medical contraindicated ☐ Offered & declined ☐ Not offered
☐ Inability to obtain influenza vaccine ☐ None of the above

PAIN ASSESSMENT

☐ None ☐ Acute ☐ Chronic ☐ Intermittent ☐ Sharp ☐ Dull
☐ Other (explain) ______
LOCATION:
INTENSITY (1 - 10)

ISOLATION

☐ MRSA ☐ VRE ☐ ACINETOBACTER ☐ CDIFF ☐ ESBL

Site:

Other Instructions:

Activities of Daily Living

Activity	Independent	Supervison	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**
☐ GOOD	☐ AMPUTATION
☐ FAIR	☐ PROSTHESIS
☐ POOR	☐ PARALYSIS
☐ HYPERALIMENTATION	☐ PARESIS
☐ FEEDING TUBE	☐ CONTRACTURES
MENTAL STATUS	**BEHAVIOR**
☐ ALERT	☐ COOPERATIVE
☐ ORIENTED	☐ BELLIGERENT
☐ DISORIENTED	☐ COMBATIVE
☐ FORGETFUL	☐ NOISY
☐ UNRESPONSIVE	☐ ABUSIVE
☐ DEPRESSED	☐ 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

☐ IMPLANTABLE DEVICE
Type ______

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:

AKRON REGIONAL HOSPITAL ASSOCIATION

PHYSICIAN ORDERS AND TRANSFER OF CARE FORM

COPY AND SEND **TO THE NURSING FACILITY IN THE ORDER LISTED**

Chart Form	Content Needed for Admission	Check Off
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	