Provider Admission Orders for Assisted Living Home

Patient : _____ Date of Birth: _____

Assisted Living Home: _____ Phone: _____

Provider: _____ Provider number: _____

Provider Fax: _____ Office number: _____

MPOA: _____ Phone Number: _____

Code Status: Full DNR Mortuary: _____

Reason for Evaluation:

☐ Pre-Admission ☐ Annual ☐ Change in condition ☐ Other: _____

Current Diagnosis: _____

Physical Limitations: _____

Mental Health Limitations: _____

Care Team:

☐ Home Health: _____ ☐ Hospice: _____

☐ Physical Therapy: _____ ☐ Occupational Therapy: _____ ☐ Wound Care: _____

Vitals:				
☐ Daily	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Other
Diet Order:				
☐ Regular	☐ Low Sodium	☐ Diabetic	☐ Mechanical Soft	☐ Pureed
Transfers:				
☐ Independent	☐ 1x assist	☐ 2x	☐ Transfer sheet	☐ Hoyer lift
Activity:				
☐ Independent	☐ Standby assist	☐ 1x Assist	☐ 2x Assist	☐ Bedbound

Mobility Aids: ☐ Independent ☐ Cane ☐ Walker ☐ Scooter ☐ Non-ambulatory
Showering/Bathing: ☐ Daily ☐ 1-2 Weekly ☐ 3-4 Weekly ☐ Other: _____
Skin Integrity/Wounds: ☐ None/Monitor ☐ Q2H turns ☐ Barrier Cream ☐ Pressure Relieving Device(s) ☐ Other
Fall Risk: ☐ Yes ☐ No ☐ Chair Alarm ☐ Bed Alarm ☐ Other

MEDICATION LIST

(Additional sheets may be attached if necessary)

Medication Name	Dosage	Route of Administration	Time of Administration	Scheduled (S) or PRN (P)	Notes

Medication Allergies: _____ Environmental Allergies: _____

Authorization:The manager and/or Caregiver are authorized to administer medications, refill medisets, and/or treatments to this resident. Mediset can also be filled and refilled by the pharmacy.

Provider Signature _____ Date:_____

MEDICAL PRACTITIONER'S ORDER FOR ASSISTED LIVING FACILITIES
(Medication Organizers)

Resident's Name: _____ Date of Birth: _____

Dear Medical Provider. _____,

In order to be in compliance with the Department of Health Services, we need a signed order from each Provider stating that a certified manager or caregiver may set up the medication organizers (medisets) and the certified manager and caregivers may administer the medication from the medication organizers as per Provider's instruction. Medisets may also be filled and refilled by the pharmacy distributing the medication. Please sign below signifying you are aware of our policies and the orders listed below.

_____
Manager's Signature

- The certified manager/caregivers will accept the Medical Practitioner's order from the resident's physician.
- The certified manager/caregivers or pharmacy may set up the medication organizer for the above named resident for a period of 2 weeks at a time.
- The certified manager/caregivers may administer the medication to the resident from the medication organizer according to the Prescribing Medical Provider's orders.
- All prescribed treatment may also be administered by the manager/caregivers.

_____
Provider Name (Print)

_____ _____
Provider's Signature Date

Approval of Continued Residency Completed by Medical Practitioner

The Arizona Department of Health Services (ADHS) concerning Licensure of Assisted Living Facilities Rules/ Regulations requires that a facility is unable to accept or retain a resident who is bed-bound, wheelchair-bound, or has pressure ulcers unless:

a. the following requirements are met at the onset of the condition or when the resident is accepted into the assisted living facility:

i. A written authorization of residency or continued residency is signed and dated by the resident or the representative; at least once every 6 months throughout the duration of the resident's condition.

ii. The resident's primary care provider, who has examined the resident within 30 days from the onset of the condition or upon acceptance into the assisted living facility, signs and dates a statement authorizing residency at the assisted living facility. The resident's primary care provider shall examine the resident at least once every 6 months throughout the duration of the resident's condition and sign and dates a statement authorizing continued residency;

Therefore, please complete this form for (Resident's Name) _____ .

I (Medical Practitioner) _____ hereby approve to the continued residency at (Assisted Living Home/Facility) _____ who is under my care requiring an increased need for services or who is bed bound in (Home/Facility Name)_____, an assisted living home/facility located at (address)_____. In lieu of placement in a skilled nursing facility or other acute care facilities.

I hereby authorize care to be given to my patient _____.
(Resident's name)

I last examined this patient on _____.

_____ _____
Medical Practitioner's Name Date

_____ _____
Medical Practitioner's Signature Office Phone Number

_____
Medical Practitioner's Address