COVENANT NURSING HOME ADMISSION ORDERS

1. Admit _____ (resident name) to Covenant Nursing Home.

2. **Admitting Diagnosis**: _____

_____

Allergies: _____

3. **Medications:** **Dose** **Indication**

_____

_____

_____

_____

_____

_____

_____

(If more needed, attach medication list)

4. **Treatments: (Wound care, et cetera)**

_____

_____

_____

5. **Diet**: Regular: ____ Mechanical Soft: ____ Pureed: ___ No Concentrated Sweets: ____
No Added Salt: ____ Thickened Liquids: _____Consistency: _____
Dietary Supplement: _____ Frequency: _____

6. **Weights**: Routine: _____ Weigh patient weekly: _____ Duration: _____

7 **Activity**: Independent: ____ Wheelchair ad. lib.:____ Remain in bed: ____ Up in chair: ____

8. **Activity Therapy**: As tolerated and not to interfere with treatment plan.

9. **Weight Bearing Status:** _____

10. **Labs/other diagnostic tests:**_____

_____

11. **PPD Status**: Positive History: _____(Year: _____) None: ____Two step PPD: _____
Chest X-ray, PA and left lateral: _____(Indication:_____).

12. **Rehabilitation Evaluation and Treatment as indicated**:
OT: _____ ST: _____ PT: _____ Other: _____ None: _____

13. **Optometry Eval**: Yearly: _____ Other: _____ None: _____

14. **Audiology Eval**: Yearly: _____ Other: _____ None: _____

15. **Dental Eval**: Yearly: _____ Other: _____ None: _____

16. **Podiatry Eval**: Yearly: _____ Other: _____ None: _____

17. **Siderails**: Up: Bilateral: _____ Left: _____ Right: _____ None: _____
Indications: For Safety: _____ Enablers in positioning: _____

18. **Code and Advanced Directives Status**: Full Code: _____ No CPR: _____
Do Not Hospitalize: _____ No Tube Feeding: _____ No Antibiotics: _____
Other: _____

19. **Blood Pressure Management**: For Systolic BP> 180 and or Diastolic> 110. Notify MD: _____
No Management: _____

20. **Blood Sugar Management**: Fingerstick: Frequency: _____
Sliding scale – treat fingerstick blood sugars as follows:
- Blood sugar greater than ____ but less than ____; give _____ units of regular insulin subcutaneously
- Blood sugar greater than ____ but less than ____; give _____ units of regular insulin subcutaneously
- Blood sugar greater than ____ but less than ____; give _____ units of regular insulin subcutaneously
- Blood sugar greater than ____ but less than ____; give _____ units of regular insulin subcutaneously

Notify MD for Blood Sugar < 80 or > 350: _____ No Management: _____

21. **Fever Management**: Notify MD for Temp > 100* _____ No Management: _____

22. **Immunizations**: Yearly Flu Vaccination: _____ Pneumovax: _____ When: _____
Tetanus Booster: _____ When: _____ Shingles: _____ When: _____

23. **Urinary Incontinence Management**: Incontinence Brief: _____
Catheter: External: _____ Internal: _____ Size: _____ Indication: _____
Change monthly and prn clogging/leaking _____ Proto. to discont. indwelling catheter:_____
Bladder Training: _____ Frequency: _____ Incontinence Program: _____
Suprapubic catheter Management: ____Others: _____No Management: _____

24. **Bowel Management**: Bowel Training: ___ Frequency: _____Colostomy Care: _____
For constipation: Encourage fluids _____ No Management: _____

28. **Additional Orders**:_____

_____

_____

Signature of Ordering Physician: _____ Date:_____

Phone Number: _____