



ADMISSION ORDERS

ALL ORDERS MUST BE SIGNED BY RESIDENT'S PHYSICIAN AND FAXED TO (808) 626-8817.

Resident's Name _____

Primary Physician _____

List All Current Medical Diagnoses Below:

Medications, please list below, also include PRNs and OTCs:

MEDICATION DOSE TABS ROUTE FREQUENCY DIAGNOSIS

If Hypertensive,

Check BP every Month Week Day Other: _____

Please provide BP parameters: SBP should be < ___ & > ___ DBP should be < ___ & > ___

(Residents that self-medicate will be responsible for providing their own BP checks except for once per month)

If Diabetic,

Blood Sugar Checks: NO Monthly Weekly Daily Other: _____

Blood Sugar parameters: Blood sugars should be < _____ & > _____

(Residents who self-medicate will conduct their own blood sugar checks)

Resident's Name _____

Medication Category (Check applicable box):

- Resident is capable of Self-Administration
- Resident requires supervision to take ALL medications Medication Administration

Treatments w/ dose and frequency (for topical medications include area of application)

Allergies (Include food, medication and environmental): _____

Diet: Please Check Applicable Diet- *(The Plaza only accepts the diets listed below. Regular diet has been stopped at The Plaza because with new regulations it is more restrictive than a No Added Salt diet.)*

_____ No Concentrated Sweets _____ No added salt

Mobility Status: _____ Ambulatory _____ Ambulatory with assistive devices
_____ Non-Ambulatory

Weight Parameters:

_____ The Plaza will weigh resident's every month and only notify physician if weights fall outside of standard parameters. The Plaza's standard weight parameters are as follows: 5% in one month; 7% in three months; 10% in six months
_____ Other parameters or frequency _____

Resident is free from communicable disease. ___Yes ___No

Other Orders:

NOTE: Continue above orders for 90 days unless otherwise specified.

Signature of Physician _____ **Date** _____

Phone # _____ **Fax #** _____

MD License # _____

Chief Complaints _____

Present Illness _____

Past History _____

Operations _____

Injuries _____

Family History _____

INVENTORY BY SYSTEMS-General _____

Skin _____

Head – EENT _____

Respiratory _____

Cardiovascular _____

Genitourinary _____

Gynecological _____

Musculoskeletal _____

Abdomen _____

Extremities _____

Neurological _____

Psycho-social _____

MOST RECENT PPD _____ 2-step Yes ___ No ___

MOST RECENT Flu vaccine _____ Pneumococcal _____ Shingles vaccine _____

PATIENT IS FREE FROM COMMUNICABLE DISEASE: YES ___ NO (specify) _____

PATIENT IS AWARE OF DIAGNOSIS: YES ___ NO _____

DIAGNOSIS _____

PHYSICIAN'S SIGNATURE _____ DATE _____

HISTORY AND PHYSICAL

RESIDENT NAME		PHYSICIAN
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