BLOSSOM SPRINGS℠

Fax the following information directly to **Jamie Smith**
FAX 248-413-8531
PHONE 248-601-0505

PHYSICIANS ORDERS — MOVE-IN

Resident: _____ **Date of Birth:** _____

Vitals Signs BP: _____ Pulse: _____ Resp: _____ Weight: _____ Height: _____

Mental Status	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Eyes	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Ears	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Nose & Throat	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Lungs	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Heart	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
GI Test	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
G.U.	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Extremities	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Neurological	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Spine	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____
Skin	❑ Normal	❑ Abnormal	*if abnormal, please explain*: _____

Diet Orders: ❑ Regular Diet ❑ NAS (no added salt) Diet ❑ No Concentrated Sweets
Does the above diet require simple textural modifications? ❑ No ❑ Yes, *please explain* _____
May be offered alcohol at community sponsored events? ❑ No ❑ Yes

T.B. Test: May have 2-step PPD at admission and then PPD annually? ❑ No ❑ Yes

Flu Shot: Date of most recent flu vaccination: _____ May have flu vaccine annually? ❑ No ❑ Yes

COVID-19 Test: May have testing at community as needed? ❑ No ❑ Yes

May have COVID-19 testing if exhibits the following symptoms or a combination of: (This list is not all inclusive)

- *Fever of 100° F or higher*
- *Cough*
- *Shortness of breath or difficulty breathing*
- *Chills*
- *Repeated shaking with chills*
- *Muscle pain*
- *Headache*
- *Sore throat*
- *New loss of taste or smell*

Pneumonia Immunization: Date of most recent Pneumonia (if known): _____
Lab Work (type and frequency):

Rehabilitation Services:

Physical therapy evaluation/treatment	❑ No	❑ Yes
Occupational therapy evaluation/treatment	❑ No	❑ Yes
Speech therapy evaluation/treatment	❑ No	❑ Yes

Additional Services:
Ophthalmology, podiatry, dental care as needed ❑ No ❑ Yes

The Physician's signature below signifies this person is not in need of 24-hour skilled nursing care, is appropriate for assisted living and is free of common disease.

Physicians Signature: _____ Date: _____

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PHYSICIANS ORDERS — MOVE-IN

Resident: **Date:**

Diagnosis:

PLEASE ATTACH THE MOST CURRENT HISTORY AND PHYSICAL FOR THIS PATIENT
LIST CURRENT MEDICATIONS AND DIAGNOSIS (PRESCRIPTIONS, OTC, PRN) OR ATTACH A LIST OF CURRENT MEDICATIONS

MEDICATION	TAKEN/AMOUNT/FREQUENCY	DIAGNOSIS	ANY PARAMETERS

Resident is aware of their medical condition ❑ No ❑ Yes
Resident may self-administer, store and coordinate all medications without staff assistance ❑ No ❑ Yes

Allergies:

Treatments:

Other Diagnosis/Problems:

Allergies/Sensitivity: ❑ No ❑ Yes,
CPR Status: ❑ Do Not Attempt CPR ❑ Attempt CPR
Activity Level: ❑ Limitations ❑ No Limitations
May Follow Community Skin Tear/Abrasion Protocol: ❑ No ❑ Yes

If community DON determines resident is safe, client may manage and administer prescriptions and over the counter medication ❑ No ❑ Yes

Additional Orders:

CONTINUE ABOVE ORDERS FOR 180 DAYS UNLESS SPECIFIED OTHERWISE

Physicians Signature: Date:

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FAX

To:	Jamie Smith	From:	
Fax:	248-413-8531	Pages:	
Phone:	248-601-0505	Date:	
Re:	New Resident	cc:	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Hello, our patient _____ , will be moving in to Blossom Springs on _____. We have completed the following tasks. Please find attached the physician move in orders and the results to the following requirements:

- Patient Medication List **– MUST be signed by physician.**
  - This includes all current medications, as well as any over the counter medication, supplements and/or vitamins the patient currently takes.
- Chest X-Ray or skin TB test report; showing free of communicable disease.
  - an individual admitted to residence in the home shall have evidence of initial tuberculosis screening on record in the home that was performed within 12 months before admission. Initial screening may consist of an intradermal skin test, a blood test, or a chest x-ray. Date of Test: _____
- COVID-19 test
  - Must be negative and results date must be no more than 72 hours before move-in date. Results / Date: _____/_____.

Please fax all items to 248-413-8531 Attention Jamie Smith.
If you have any questions, please call Jamie Smith at: 248-601-0505.
Thank you for your prompt attention to this!