Initial Medication/Treatment Plan of Care
Krishna's Home

Name: ______________________________ **Date:** ____________

Primary Care Provider (PCP) Name: ______________________________

The above person wants to be a resident at Krishna's Home Assisted Living. State regulations require we have the following orders from you. Please complete both pages of this form and sign it.

All known diagnoses:

Food and Medication Allergies:

Diet *(check one)*: ☐ as tolerated ☐ NAS ☐ NCS ☐ other:

TB Skin Test/Chest x-ray: Date: Results:

Treatments *(check one)*: ☐ none ☐ as listed below

This person requires oxygen .... ☐ Yes ☐ No

If yes ☐ PRN ☐ Continuous at ☐ 2 L ☐ 3L ____L/min

This person's code status is .... ☐ DNR ☐ Full Code

This person is diabetic and needs FSBS PRN and .... ☐ Qweek ☐ Daily ☐ 2XDay ☐ 4XDay

May we have a flu shot given annually? .... ☐ Yes ☐ No

May we administer a TB Skin Test (PPD) annually? .... ☐ Yes ☐ No

Recommended physician visit schedule: ☐ Annually ☐ every 6 months ☐ every 3 months

☐ Monthly ☐ Other ____________________

Vital signs are to be taken: ☐ Monthly ☐ Weekly ☐ Daily ☐ Other ________

Unable to be weighed because: ________________ ☐ Yes ☐ Okay to weigh

May this resident participate in daily range of motion activities? ☐ Yes ☐ No

If no, what are his/her limitations: ______________________________

Evacuation from the assisted living facility ☐ will not cause harm ☐ will cause harm & should not be done.

Name:

I approve the following medication orders for the above mentioned patient:

Med/Strength	Dose	Route	Frequency	Treats

Pain/Headache/fever >101:	Tylenol 325 mg PO 2 Q6H PRN
Indigestion:	Mylanta PO 15 cc Q4H PRN
Diarrhea:	Imodium 2 mg PO 1 tab QID PRN
Constipation:	30 cc Milk of Magnesia PO QD PRN
Cough:	Adult tussin DM PO 2 tsp Q4H PRN
Abrasions: Antibiotic ointment –topical	Thin layer to abrasion; cover with bandage/clean dressing QD PRN
Barrier cream to bottom with brief change PRN prevention of skin breakdown	

Discontinue all medications not on the above list. I have examined the person on the date below. I have reviewed and approved this person's medication regimen. I hereby authorize all certified caregivers/manager of Krishna's Home Assisted Living to fill mediset and/or administer all medication and treatments I prescribe for the above-mentioned patient whenever the patient is a resident in the home, I do not need to authorize each individual person. I have read and approve the medication policies/procedures and Scope of Services of Krishna's Home. I also authorize the manager or their designee to act as my agent when taking telephone orders and faxing orders to the pharmacy of resident's choice.

This person ☐ ambulates ☐ is wheelchair/chair confined per DHS regulations. Krishna's Home assisted living can meet the resident's needs, is within their scope of service and based on assessment on the date below I approve the resident to stay at Krishna's Home.

PCP Name:________________ Signature:________________________ Date:________

Initial Assisted Living Determination

Name: ______________________________________

Dear Healthcare Provider: Arizona State Regulations require the following information be provided by a *licensed physician, nurse practitioner, physician's assistant or registered nurse;* no earlier than 90 days prior or no later than upon acceptance into an assisted living facility. Please check appropriate boxes and sign this form.

☐ **Yes** ☐ **No** This person has a stage 2, 3 or 4 decubitus ulcer (if yes the following must be true)

☐ **Yes** ☐ **No** This person needs intermittent nursing or medical care and Home health/hospice has been arranged for this person.

☐ **Yes** ☐ **No** This Person needs only Supervisory Care if the person only needs the care designated by checking the boxes below.

- ☐ This person has good safety awareness and can make their needs known
- ☐ This person needs only general supervision NO HANDS ON ASSISTANCE.
- ☐ This person can self-administer medications, including FSBS, eye drops, ear drops

☐ **Yes** ☐ **No** This Person needs Personal Care if any of the boxes below are checked.

- ☐ This person needs hands on assist with any activities of daily living (ADL)
- ☐ The care this person needs can be performed by certified caregivers who don't have professional skills. Certified caregiver actions may include assistance with ADLs, coordination of intermittent nursing services and medication administration.

☐ **Yes** ☐ **No** This person needs Directed Care if any of the boxes below are checked.

- ☐ This person is unable to recognize danger
- ☐ This person is unable to summon assistance
- ☐ This person is unable to express their needs
- ☐ This person is incapable of making basic decisions about their care

☐ **Yes** ☐ **No** Does this person require behavioral care that can be provided by caregivers?

☐ **Yes** ☐ **No** This person is unable to stand or walk on their own? (*A yes requires approval of a physician, nurse practitioner or physician's assistance prior to acceptance into an assisted living facility.)*

A YES below means this person is NOT appropriate for assisted living.

☐ **Yes** ☐ **No** Does this person require chemical or physical restraints?

☐ **Yes** ☐ **No** Does this person require continuous behavioral health care?

☐ **Yes** ☐ **No** Does this person require continuous medical care or care provided by an RN/LPN?

By signing below I attest that the above information is true and accurate as of the date below.

Name: ____________________ Signature: ____________________ Date: __________