Nursing Home Disaster Struck Facility #1

ATTACHMENT A: PATIENT / MEDICAL RECORD & EQUIPMENT TRACKING SHEET

Patient MR # or Tracking #	Date of Birth	Patient Name	Sex	Time Left Bldg.	Name, Type of and # Transport (State if applicable)	Original Chart Sent w/ Patient (Y) (N)	Meds & MAR Sent w/ Patient (Y) (N)	Equipment Sent	Family Notified: Name, Date & Time, Phone Number w/ Area Code	Y	N	PCP Notified Name, Phone Number, Date & Time	Y	N	Time Arrived Stop-over / Time Left	Time/ Date Arrived at Patient Accepting Facility
1	10/17/30	NH Resident 1	M	0930	MAP Member Bus #1	Y	Y	Cane	Daughter 9:15 AM	✓			✓		A / L ✓	
2	3/1/57	NH Resident 2	F	0930	↓	Y	Y	Cane	Son 9:15 AM	✓			✓		A / L ✓	
3	5/14/34	NH Resident 3	M	0930	↓	Y	Y	Walker	Daughter 9:15 AM	✓			✓		A / L ✓	
4	11/20/36	NH Resident 4	F	0930	↓	Y	Y	Walker	Son 9:15 AM	✓			✓		A / L ✓	
5	10/31/61	NH Resident 5	F	0930	↓	Y	Y	Walker / w/c	Son 9:15 AM	✓			✓		A / L ✓	
6	8/20/38	NH Resident 6	F	0930	↓	Y	Y	w/c	Son 9:15 AM	✓			✓		A / L ✓	
7	8/24/49	NH Resident 7	M	0930	↓	Y	Y	Walker	Daughter 9:15 AM	✓			✓		A / L ✓	
8	11/2/58	NH Resident 8	F	0930	↓	Y	Y	Walker w/c	Son 9:15 AM	✓			✓		A / L ✓	
9	11/19/39	NH Resident 9	F	0930	↓	Y	Y	Cane	Son 9:15 AM	✓			✓		A / L ✓	
10	7/7/45	NH Resident 10	F	0930	↓	Y	Y	Walker	Son 9:15 AM	✓			✓		A / L ✓	

Disaster Struck Facility: Keep One Copy / ☐ FAX 1 copy to RCC / ☐ FAX 1 copy to Receiving Facility / ☐ GIVE 1 copy to Transporters

Patient Accepting Facility: Have you communicated to RCC or Disaster Struck Facility that you received these residents? ☐ YES / ☐ NO

Patient Accepting Facility: Print Name of Key Contact / Phone # / Fax: _____

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #1 PHONE _____

RESIDENT'S NAME NH Resident 1 DOB 10/17/1930

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

COPD, CHF, HTN

TREATMENTS: Lasix, ASA, Lisinopril, Xoponex, Advair

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / (N))
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☐ Verbally Aggressive ☑ Physically Aggressive ☑
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☑ Partial Assist ☐ Total Assist ☐
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid (L) / (R) Dentures (U) / (L) Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☑ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate 2Lpm Mask _____ Cannula ✓ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF # 1 PHONE _____

RESIDENT'S NAME NH Resident 2 DOB 3/1/1955

LANGUAGE(s) SPOKEN Eng, Sp ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

ASA, Senna, Xoponex

TREATMENTS: UTI, PNU, Foley Cath, CU

ALLERGIES: ~~NKA~~ NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y (N))
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☐ Verbally Aggressive ☑ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☑ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET Regular
Diabetic ☐ Last Insulin _____ Last Meal PM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☑ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☑ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF #1 PHONE _____

RESIDENT'S NAME NH Resident 3 DOB 5/14/1934

LANGUAGE(s) SPOKEN English French ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

Dementia, Anemia

TREATMENTS: Insulin, Iron

ALLERGIES: Peanuts

FACILITY PHARMACY: Duncane PHONE: _____

DNR ORDER: (Y) / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☐ Lethargic ☑ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☑ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☑ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☑ Total Assist ☐
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET Regular
Diabetic ☐ Last Insulin _____ Last Meal _____ Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☑ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☑ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate 3 Mask _____ Cannula ✓ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF – NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF # 1 PHONE _____

RESIDENT'S NAME NH Resident #4 DOB 11/20/1936

LANGUAGE(s) SPOKEN English / Spanish ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

HTN, DDDM, CHF

TREATMENTS: Amlopidine, Lasix, Colace, Insulin

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: (Y) / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☑ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☐ Total Assist ☑
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☑ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid (L) (R) Dentures (U) (L) Contact Lens ☐

DIET Regular
Diabetic ☐ Last Insulin _____ Last Meal _____ Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF #1 PHONE _____

RESIDENT'S NAME NH Resident 5 DOB 10/21/1961

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE Y / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

(R) Knee Replacement — Rehab

TREATMENTS: Colace, Valsan, Metrin

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☑ Total Assist ☐
Continent ☑ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET Regular
Diabetic ☐ Last Insulin _____ Last Meal _____ Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☐ Partial Assist ✓ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☐ Partial Assist ✓ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☑

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #1 PHONE _____

RESIDENT'S NAME NH Resident 6 DOB 8/20/1938

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE Y / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

Dementia, Resp Failure, CHF

TREATMENTS: ASA, Lasix, Risperdal, Morphine

ALLERGIES: Shellfish, PCN

FACILITY PHARMACY: Pharmamerica PHONE: _____

DNR ORDER: Y / N Other _____ No Hospitalization ✓
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☐ Total Assist ☑
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☑ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal _____ Kosher ☐

Thickened Liquids ☑ Consistency: _____

NPO ☐ Aspiration Precautions ☑ Modified Diet _____

Tube Feed ☐ Type _____ Rate _____

TRANSFERS
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☑

MOBILITY
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2 Total ☑

EQUIPMENT: None ☐ Cane ☐ Walker ☐ Wheelchair ☑

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☑ Type MRSA C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate 4 Mask _____ Cannula ✓ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #1 PHONE _____

RESIDENT'S NAME NH Resident 7 DOB 8/24/1949

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

HTN, CVA, Seizures, Aphasia (R) sided weakness

TREATMENTS: PT/OT, Clonidine, Diazepam

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☐ Total Assist ☑
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☑ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☑

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF #1 PHONE _____

RESIDENT'S NAME NH Resident DOB 11/2/1950

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Polish (primary) Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

~~Renal Failure, T2DM, CHF, HTN,~~ Dialysis

TREATMENTS: Insulin, K+, Metformin, Lasix ASA

ALLERGIES: NKDA Dialysis M/W/F

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☑ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☑ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☑ Total Assist ☐
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☑ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U L Contact Lens ☐

DIET
Diabetic ☑ Last Insulin 8Am Last Meal 8Am Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☑

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☑ M/W/F

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #1 PHONE _____

RESIDENT'S NAME NH Resident 9 DOB 11/19/1939

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N
French (Primary)

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

~~EDOM~~, Rheumatoid Arthritis, A-Fib

TREATMENTS: PT/OT, Prednisone, Lantus, Coumadin

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: (Y) / N Other DNI No Hospitalization ✓
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☑ Partial Assist ☐ Total Assist ☐
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☑ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐
Prosthesis

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8 AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type _____ Rate _____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☑ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #1 PHONE _____

RESIDENT'S NAME NH Resident 10 DOB ~~11/19/1935~~ 7/7/1945

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

~~Epilepsy~~ CVA, Dementia

TREATMENTS: PT/OT, Risperdal, Colace, Synthroid

ALLERGIES: NKDA

FACILITY PHARMACY: Unknown PHONE: _____

DNR ORDER: (Y) / N Other DNR No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☑ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☐ Verbally Aggressive ☑ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☐ Supervision ☐ Partial Assist ☐ Total Assist ☑
Continent ☐ Incontinent Bladder ☑ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures (U) / L Contact Lens ☐

DIET Regular
Diabetic ☐ Last Insulin _____ Last Meal 8 AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☐ Supervision ☑ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2 Total ☑

EQUIPMENT: None ☐ Cane ☐ Walker ☑ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

O_2 Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - NH

PHONE # _____ CONTACT _____

Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below

ATTACHMENT C: INFLUX OF PATIENTS LOG

(Accounting for Incoming Patients and Equipment)

Make additional copies prior to use

1. FACILITY NAME	2. DATE/TIME PREPARED	3. INCIDENT DESCRIPTION

4. TRIAGE AREA (for entry into the facility)

Arrival Time	Facility Received From	MRN# / Triage #	Pt Name (Last, First)	Sex	DOB/ Age	Original Chart Received w/ Resident (Y) (N)	Meds & MAR Received w/ Resident (Y) (N)	Equipment Received	Family Notified: Name, Date, Time, Phone Number w/ Area Code			PCP Notified: Name, Date, Time, Phone Number w/ Area Code			Time Left Triage/ Destination
									Y	N		Y	N		

5. SUBMITTED BY	6. PHONE NUMBER	7. DATE/TIME SUBMITTED

ATTACHMENT C: INFLUX OF PATIENTS LOG

(Accounting for Incoming Patients and Equipment)

Make additional copies prior to use

1. FACILITY NAME	2. DATE/TIME PREPARED	3. INCIDENT DESCRIPTION
4. TRIAGE AREA (for entry into the facility)		

Arrival Time	Facility Received From	MRN# / Triage #	Pt Name (Last, First)	Sex	DOB/ Age	Original Chart Received w/ Resident (Y) (N)	Meds & MAR Received w/ Resident (Y) (N)	Equipment Received	Family Notified: Name, Date, Time, Phone Number w/ Area Code			PCP Notified: Name, Date, Time, Phone Number w/ Area Code			Time Left Triage/ Destination
									Y	N		Y	N		

5. SUBMITTED BY	6. PHONE NUMBER	7. DATE/TIME SUBMITTED