Summerset
SENIOR LIVING

Welcome to Summerset Senior Living

We are excited to welcome you to our family. We appreciate the initial trust you have placed in us and will work tirelessly to build upon it.

The transition from your current living situation requires completion and presentation of standard documents required by the State of Nevada, Department of Health and Human Services which is the licensing and regulatory division for Assisted Living Communities. **These documents must be completed a minimum of 10 business days prior to the actual move in date.** The attached documents include:

_____ Physician documentation (5 pages), commonly referred to as the History and Physical (H&P). Most physicians require an appointment with the patient to complete these forms.

_____ Physician Signed Non-Secure Letter

_____ Diet Clarification

_____ PRN Authorization Form

_____ Physician Order for Motorized Scooter (If applicable)

_____ POLST

_____ Tuberculosis Testing (TB) - Please provide your patient with a Lab Order for a QuantiFERON Gold TB Test Blood Draw. If the test is positive, please provide Chest X-Ray Lab Order. PLEASE KEEP IN MIND RESULTS FROM THIS TEST TYPICALLY TAKE 3 TO 4 DAYS TO RECEIVE.

Should you require assistance in obtaining or completing any of the documents, please contact the Move In Coordinator or Community Relations Director. Kindly present completed documents via email as attachments or fax to (775) 391-8686. You can also drop off paperwork in person.

We look forward to welcoming you to your new home.

Jesse Barrios, Executive Director

SUMMERSET
SENIOR LIVING

History & Physical/Assessment

Resident Name: _____ DOB: _____ Date: _____

Physician Name: _____ Physician Phone: _____

Please Check One: □ **Admission** □ **Annual**

HISTORY AND PHYSICAL

Diagnosis: _____

Height: _____ Weight: _____ Temperature: _____

Pulse: _____ Respiration: _____ Blood Pressure: _____

Ears/Hearing Hearing aids: Yes □ No □ Concerns: _____

Nose/Throat Swallowing difficulty: Yes □ No □ Concerns: _____

Eyes Cataracts: Yes □ No □ Macular Degeneration: Yes □ No □ Concerns: _____

Skin Normal Yes □ No □ Special condition:

_____

Heart Normal: Yes □ No □ Special condition: _____

Lungs Normal Yes □ No □ Oxygen required at _____ liters. Concerns: _____

Abdomen Normal Yes □ No □ Concerns: _____

Extremities Normal: Yes □ No □ Range of motion limited: Yes □ No □

Needs: (check all that apply) Walker □ Cane □ Wheelchair □ Glasses □ Dentures □

Resident is oriented to: (check all that apply) □ Person □ Place □ Time

Allergies: _____

Alcohol use: If this patient should limit alcohol consumption, please specify restrictions:

_____

This is a Nevada Licensed Assisted Living Community with 24-hour non-licensed staff.

In your professional opinion, is this patient appropriate for this model? Yes □ No □

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History & Physical/Assessment

Resident Name: _____ DOB: _____

Ambulatory Status:

Category 1 - Yes □ No □ Definition: A resident who, without assistance of any other person, **is** physically and mentally capable of moving from the room where they sleep to the other side of a smoke or fire barrier or outside the facility, whichever is nearest, in 4 minutes or less.

Category 2 - Yes □ No □ Definition: A resident who, without assistance of any other person, **is not** physically and mentally capable of moving from the room where they sleep to the other side of a smoke or fire barrier or outside the facility, whichever is nearest, in 4 minutes or less.

Please describe any Cognitive Deficits: _____

_____

Physician Signature: _____ Date : _____

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History & Physical/Assessment

Resident Name: _____ DOB: _____

All prescribed medications and over the counter medications, vitamins, herbal supplements, nutritional drink, etc., must be listed below.

**** ALL CONTROLLED MEDICATIONS REQUIRE A HANDWRITTEN PRESCRIPTION THAT MEETS THE STATE AND FEDERAL REQUIREMENT ****

MEDICATION

Scheduled Medications: (Please complete all areas requested for each medication)

Drug Name	Dosage to be Dispensed	Tabs/Caps? And How Many?	Frequency of Administration	Route to be Administered	Diagnosis	Number of Meds to be Dispensed	Number of Refills

RESIDENT MAY KEEP MEDICATIONS IN APARTMENT AND SELF- ADMINISTER

DO NOT ATTACH MEDICATION LIST TO THIS FORM -- PLEASE COMPLETE THIS FORM IN ENTIRITY

Physician Signature: _____ Date: _____

History & Physical/Assessment

Resident Name: _____ DOB: _____

All prescribed medications and over-the-counter medications, vitamins, herbal supplements, nutritional drinks, etc., must be listed below.

**** ALL CONTROLLED MEDICATIONS REQUIRE A HANDWRITTEN PRESCRIPTION THAT MEETS THE STATE AND FEDERAL REQUIREMENT ****

PRN MEDICATIONS

Drug Name	Dosage to be Dispensed	Tabs/Caps? And How Many?	Frequency of Administration	Route to be Administered	Specific symptoms indication needs for use	Number of Meds to be Dispensed	Number of Refills

Drug Allergies: _____

DO NOT ATTACH A LIST TO THIS FORM – PLEASE COMPLETE THIS FORM IN ENTIRITY

Physician Signature: _____ Date: _____

History & Physical/Assessment

Resident Name: _____ DOB: _____

Treatment for Minor Abrasions/Cuts/ Skin Tears/ etc.:

This Community provides emergency basic first aid treatments that include: cleanse wound with wound cleaner or water, apply triple antibiotic ointment, cover with bandage, change daily and as needed, notify physician of any swelling, discharge or redness and discontinue when healed. If further treatment is necessary, a home health referral will be required. Physician will be notified of such an occurrence to obtain a home health order.

ORDERS

I give permission to administer a Mantoux (Tuberculosis) 2-step skin test or Quantiferon:
□ Yes □ No

A Mantoux (Tuberculosis) test is contraindicated due to:

_____

I give permission to administer an influenza vaccine annually: □ Yes □ No

Influenza vaccine is contraindicated due to:

_____

Pneumovax vaccine in accordance with CDC guidelines? □ Yes □ No

Date of last Pneumovax:

_____

Medication Administration:(please check one)

□ Resident is able to self-administer all medications both prescribed and OTC. Resident is capable of storing and coordinating medications without staff assistance.

□ Resident is NOT able to self-administer medications, prescriptions or OTC. Staff will centrally store medications and provide assistance in administration.

Physician Signature: _____ Date: _____

SUMMERSET

Diet Clarification

Resident Name: _____ DOB: _____ APT: _____

Your patient desires to move into our community, Summerset Senior Living. We are asking for your help in caring for this person. We are able to provide a no added salt diet, mechanical soft diet, puree diet, and a no concentrated sweets diet as part of our services. If a resident requires a more specialized diet, he or she must be able to manage it on his or her own.

If you have any questions or require further information, please call us at (775) 553-5634

Thank you for your assistance in this matter.

Diet Clarification

_____ Resident can self-manage diet.

_____ Resident **cannot** self-manage diet.

_____ No dietary restrictions.

_____ Resident requires an NAS (no added salt) diet.

_____ Resident requires an NCS (no added sugar) diet.

_____ Resident can consume alcohol.

_____ Resident **cannot** consume alcohol

_____ Resident dietary **allergies**, please list:

_____

_____

Physician Signature_____ Date _____

SUMMERSET
SENIOR LIVING

PHYSICIAN SIGNED NON-SECURE LETTER
(ASSISTED LIVING)

Patient Name: _____ Date of Birth: _____

Provider Name: _____

Provider Phone Number: _____ Fax: _____

Provider Address: _____

City: _____ State: _____ Zip code: _____

The above-mentioned resident has a diagnosis of Dementia, or a different form of cognitive impairment Yes_____ No_____ and is appropriate to reside in a non-secured Assisted Living community.

Physician Signature_____ Date_____

SUMMERSET
SENIOR LIVING

PHYSICIAN SIGNED STANDARD PLACEMENT FORM
(MEMORY CARE)

Patient Name: _____ Date of Birth: _____

Provider Name: _____

Provider Phone Number: _____ Fax: _____

Provider Address: _____

City: _____ State: _____ Zip code: _____

The above-mentioned resident has a diagnosis of Dementia, or a different form of cognitive impairment Yes_____ No_____ and is **NOT** appropriate to reside in a non-secured Assisted Living community, they require a secured memory care community.

Physician Signature_____Date_____

PRN Authorization Form

Dear Doctor _____

Re: Your Patient_____

A Resident of Summerset Senior Living, a licensed Resident Care Facility for the Elderly

To receive nonprescription and prescription PRN medications, state regulations require that either:

1) your patient be capable of determining his/her own need for medication, or
2) for nonprescription medication only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication or clearly communicate the symptoms for a nonprescription medication then you, the physician, must be contacted before the PRN medication can be given. Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine his/her own need for PRN medications and to inform you of any changes which indicate he/she can no longer make these decisions.

Thank you for your assistance.

Sincerely,

Signature: _____Title: _____

Telephone Number: _____ Date: _____

Please check which circumstance describes your patient.

☐ My patient can determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.

☐ My patient cannot determine his/her own need for prescription and nonprescription PRN medication but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.

☐ My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot communicate his/her symptoms indicating a need for a nonprescription medication.

Physician Name: _____

Physician Signature: _____Date: _____

Summerset

PHYSICIAN ORDER FOR MOTORIZED SCOOTER

Patient Name:_____ Date of Birth:_____

Provider Name:_____

Provider Phone Number:_____ Fax:_____

Provider Address:_____

City:_____State:_____Zip:_____

The above-mentioned resident has need for a motorized scooter due to ambulation concerns.

Yes:_____ No:_____

Physician Signature:_____

Date of Signature:_____

NEVADA POLST (Provider Order for Life-Sustaining Treatment)
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

SIDE 1: Medical Orders

Consult this form ONLY when patient lacks decisional capacity. **First** follow these orders, **then** contact physician/APRN/PA. Any section not completed implies full treatment for that section.

Last Name/First/Middle Initial		
Date of Birth (mm/dd/yyyy)	Last 4 SSN	Gender
/ /	____ ____ ____	M F

A — Choose 1

CARDIOPULMONARY RESUSCITATION (CPR) – *Patient/resident has no pulse and is not breathing*

☐ Attempt Resuscitation (CPR) ☐ Do Not Resuscitate (Allow Natural Death)_____

When not in cardiopulmonary arrest, follow orders in Section B and C

B — Choose 1

MEDICAL INTERVENTIONS – Check only one – *Patient/resident has pulse and/or is breathing.*

☐ **Full Treatment.** ***Goal - prolong life by all medically effective means***
Full life support measures provided, including intubation, mechanical ventilation and advanced airway intervention in addition to treatment described in Comfort-Focused Treatment and Selective Treatment. Transfer to hospital/admit to ICU as indicated.
*Other Instructions:*_____

☐ **Selective Treatment.** ***Goal - treat medical conditions as directed below:***
In addition to Comfort-Focused Treatment, use medical treatment/IV antibiotics/IV fluids/cardiac monitor as indicated. No intubation, advanced airway interventions or mechanical ventilation. May use non-invasive positive airway pressure. Hospital transfer as indicated. Generally, avoid ICU.
*Other Instructions:*_____

☐ **Comfort-Focused Treatment.** ***Goal - maximize comfort through symptom management.***
Relieve pain and suffering with medication by *any route* as needed; may use oxygen or suctioning and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital *only* if comfort needs cannot be met in current location.**
*Other Instructions:*_____

C

ARTIFICIALLY ADMINISTERED NUTRITION & FLUIDS – *offer food & fluids by mouth if feasible or desired*

☐ Long-term artificial nutrition or feeding tube
☐ Artificial nutrition/feeding tube trial no longer than_____
☐ No artificial nutrition or feeding tube
☐ IV fluids trial no longer than _____
☐ No IV fluids
*Other Instructions:*_____

D — Required

CAPACITY DETERMINATION – Completion required by Provider (MD, APRN or PA)

At the time of completion of this medical order, the patient:
☐ Has decisional capacity **☐ Lacks decisional capacity**
to understand and communicate their health care preferences for options in this medical order.

E — Bolded Items Required

VALIDATING SIGNATURES (Required) – Advance Directive & Surrogate Information on Side 2

Date (Required)	**Physician/APRN/PA Signature (Required)**	**Physician/APRN/PA License # (Required)**

Physician/APRN/PA Name (Printed, Required)	Physician/APRN/PA Phone

Patient / Agent (DPOA-HC) / Parent of Minor / Legal Guardian (circle one)
I have discussed this form, its treatment options and their implications for sustaining life with my/the patient's health care provider. This form reflects my wishes/the patient's best-known wishes.

Signature_____ Print Name _____ Date_____

OR if the patient lacks capacity *and* has no known Agent (DPOA-HC) or guardian, complete the following:

Health Care Surrogate Authorization *Also Requires Completion of Side 2, #1.C.*

Signature_____ Date_____

Send original with patient when discharged or transferred