Physician Move-In Orders

Resident Name: _____ **D.O.B:** _____

Primary Diagnosis:

_____

_____

Allergies: (Include food, drug and other):

_____

_____

Diet Needs: (circle) Regular No Added Salt Controlled Carbohydrates

Other: _____

Is this resident appropriate for Assisted Living? (circle) Yes No

Does this resident need Memory Care? (circle) Yes No

Is this person free of communicable disease? (circle) Yes No

Communicable Disease: TB test/Mantoux last done: _____ Results: _____

OR Chest X-Ray (< 1 yr.): _____ Results: _____

Annual Flu Vaccine: (circle) Yes No Last dose: _____

Pneumo Vaccine: _____ **Shingles Vaccine:** _____ **Other Vaccines:** _____

Physician's Name: _____

Address: _____

Phone: _____ **Fax:** _____

Physician's Signature: _____ **Date:** _____

Resident Name:_____ **D.O.B.:**_____

***Sign here for medication/treatment orders**

Physician's Signature: _____ **Date:** _____

MEDICATION	DOSE	FREQUENCY	ROUTE	DIAGNOSIS/COMMENTS
*See Attached Medication List Or list current Med Orders				

Treatment Orders:

_____

_____