[FACILITY LETTER HEAD]

|  |  |
| --- | --- |
| **Date** |  |
| **Send To** |  |
| **Attention** |  |
| **Fax Number** |  |
| **Number of pages (including cover sheet)** |  |

Dear Physician,

Your patient, \_\_\_\_\_\_\_\_\_\_ is to be admitted to [FACILITY NAME] on the following date:
[DATE].

To ensure all components of the Admission Package are included, provided below is a checklist of documentation and information to include in your **2 page section** (p. 2-3):

EMR printouts are acceptable for the following:

 [ ]  Medical History

 [ ]  Current Medications

 [ ]  Signed and dated

 [ ]  Lab results

 [ ]  Allergies

Additional documentation / information to include:

 [ ]  M.O.S.T. Designation / DNR Status

 [ ]  Discretionary Orders

 [ ]  Advanced Care Planning (if documented)

 [ ]  MMSE / MOCA

[ ]  Vaccinations

In order to process admission, we require the attached Admission Package to be completed by [**DATE / TIME**].

Please fax completed package to [**FAX NUMBER**]

Thank you.
We appreciate your timely response.

Thank you.
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|  |  |  |  |
| --- | --- | --- | --- |
| **Completed by:**  |  | **Signature**  |  |
| **On behalf of:** | [Facility] |

FACILITY TO COMPLETE

|  |
| --- |
| **RESIDENT INFORMATION** |
|  |  |  |
| Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Middle name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PHN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Room: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Admit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Admitted from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Facility phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Facility fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **FAMILY CONTACT INFORMATION** |

|  |  |  |
| --- | --- | --- |
| **PRIMARY CONTACT** |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Healthcare Decision maker?  | YES [ ]  NO [ ]  |  |
| Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone (cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SECONDARY CONTACT** |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Healthcare Decision maker?  | YES [ ]  NO [ ]  |  |
| Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone (cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Baseline Measurements**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Height (cm): |  | Weight (kg) |  | Temp: |  |
| BP: |  | Pulse: |  | Sp02: |  |

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN TO COMPLETE PAGES 2 & 3

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PHN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **DOCUMENTATION** |

|  |  |  |
| --- | --- | --- |
| M.O.S.T. Designation | [ ]  Yes [ ]  No/Not Known | [ ]  Attached  |
| **OR** |  |  |
|  |  |  |
| DNR Status  | [ ]  For Resuscitation [ ]  Do Not Resuscitate  | [ ]  Not Known |
| Discretionary Orders  | [ ]  Completed | [ ]  Attached |
|  |  |
| Advanced Care Planning Conversation | [ ]  Yes [ ]  No |
|  |  |
| Recent MMSE / MOCA  | [ ]  Yes [ ]  No | [ ]  Attached  |

|  |
| --- |
| **PATIENT HEALTH INFORMATION**  |

Please provide the following information to the best of your knowledge or provide information from your Electronic Medical Record.

[ ]  EMR Printout attached

**Medical History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Current Medication(s):**

[ ]  EMR Printout attached
[ ]  Signed and dated

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Lab Results:**

[ ]  EMR Printout attached

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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[ ]  EMR Printout attached

**Allergies:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Vaccinations:***Please indicate all known vaccinations. If you do not have information, please check ‘Unknown’*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Unknown

[ ] TB / Chest x-ray (within one year) [ ]  Requisition if x-ray not available
[ ]  Tetanus [ ]  Flu [ ]  Pneumovax

**Additional comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Ordering Provider signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you.
We appreciate your timely response.