[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.