|  |  |
| --- | --- |
| Primary Contact Person/ Medical Rep /STDM |  |
| Contact information |  |

Date Started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT LABEL

|  |
| --- |
| **Events Leading to Placement** |
|  |

Medical History

|  |
| --- |
| **Ongoing Symptoms, Diseases and Current Treatment (Problem List)** |
|  |
| Dementia (Type, Cognitive Losses, Care Strategies) |
| **Previous Diagnoses and Surgical History** |
|  |
| Drug Dependencies, Smoking History |

Medications

|  |  |
| --- | --- |
| **Medication History and Reconciliation** | Sources Consulted:  |
| Medication | Reason to Keep or Stop | Stop | **Continue** | Change |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |
| 8. |  |  |  |  |
| 9. |  |  |  |  |
| 10. |  |  |  |  |
| 11. |  |  |  |  |
| 12. |  |  |  |  |
| Changed Medication from Above or New Medication on Admission |
|  |
| Medication Allergies:  |

Function

|  |
| --- |
| **Current Functional Status**  |
| *Ambulating*: Independent / Assist / Dependant: | *Transferring*: Independent / Assist / Dependant: |
| *Toileting*: Independent / Assist / Dependant: | *Bathing*: Independent / Assist / Dependant: |
| *Hygiene*: Independent / Assist / Dependant: | *Eating*: Independent / Assist / Dependant: |
| Bowel History |
| Other |

Social History

|  |
| --- |
| Hobbies, Interests, Achievements, Local supports |
| Other |

Goals of Care

|  |  |
| --- | --- |
| **Best Possible Goals of Care** | Date Collected:  |
| Sources Consulted:  |
| What function in important to maintain? |
| What symptoms are important to manage? |
| How much should we emphasize survival over comfort? |
| How do we minimize the burden to the caregivers/family? |
| When do you want to transfer to acute care? |
| Where should the care be provided at the end of life? |
| **Levels of Intervention Choose from below:** |
| Allow Natural Death Full Resuscitation |
| M1: Supportive care, symptom management &comfort measures. Transfer to higher level of care only if patient’s comfort needs are not met in current location |
| M2. Utilize all medical treatments available within current residential care facility. Transfer to higher level of care only if patient’s comfort needs are not met in current location |
| M3. Full medical treatment including critical care C1. Excluding intubation C2. Including intubation and resuscitation |

Objective

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| Relevant Labs And Imaging Results: |
| Physical exam |

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| OTHER |
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Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_