|  |  |
| --- | --- |
| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_