Congregational Home
13900 W. Burleigh Rd Brookfield, WI 53005 Ph: 262-781-0550 **Fx: 262-781-0559**

Admission Medical Summary for SKILLED NURSING FACILITY (4 Pages)

Updated 4-29-21

In order to admit to Congregational Home, the following is required: This Admission Medical Summary (AMS), which includes History & Physical; Current Medications / Treatments; Orders; Free From Communicable Disease Statement including TB and COVID (a copy of a COVID test done within 5 days prior to admission must be attached). AND Original Hard Copy Prescriptions for Controlled Substances 2 - 5 must be attached.

****A Physician Must Sign this Form Within 5 Days Prior to the planned Admission date of_____to Congregational Home. A PA, NP or RN cannot sign this form.****

If patient can't make their own Medical Decisions due to Mental Incapacity, a valid Healthcare Power of Attorney and Activation Form Signed by two (2) Physicians stating patient is Mentally Incapacitated is also Required for Admission.

Patient Name_____DOB_____

Current Status:

Current Diagnoses / Active Problems for which patient is receiving treatment_____

_____

_____

_____

Current Complaints / Symptoms_____

_____

_____

_____

History:

Past Medical History / List of Diagnoses (Dementia, Diabetes, Stroke, Seizure, Cancer, etc.)_____

_____

_____

_____

_____

_____

Past Surgical History (Type & Date)_____

_____

_____

Last Hospitalization: Date_____Where_____

Why_____

Substance Use History: Smoking_____**Alcohol**_____

Smokeless Tobacco_____Vaping_____Drugs_____

PHYSICAL EXAM / Review of Systems:

Temp_____BP_____Pulse_____
Resp_____PulseOx _____

Height_____**Weight**_____

Constitutional / General Appearance_____

Head_____

Eyes_____

Ears / Nose / Throat_____

Mouth_____

Face_____

Neck (Thyroid, Carotids)_____

Back_____

Breasts_____

Resp / Lungs_____

Cardiovascular / Heart_____

Hematologic_____

Endocrine_____

Abdomen_____

Gastrointestinal_____

Genitourinary_____

Pelvic / Rectal_____

Musculoskeletal_____

Extremities (Restrictions, Edema, etc)_____

Lymph_____

Pulses_____

Skin / Integumentary_____

Neurologic_____

Psych / Behavioral / Mental Status_____

Labs (if pertinent):

CBC_____FBS_____
Urinalysis_____Other_____

Imaging (if pertinent):

Note: A Chest X-Ray is required Only if patient has a History of Tuberculosis or is a known Positive Reactor, in which case the Chest X-Ray must be completed Within **30** days Prior to Admission to Congregational Home

_____

_____

Current Medications: (Name, Dosage, Frequency, **Corresponding Diagnosis**)_____

****Original Hardcopy Prescriptions for Controlled Substances Level 2 – 5 Must Come with Patient Upon Admission to Congregational Home****_____

_____

_____

_____

_____

_____

Medication Administration:

Note: Licensed Nursing Personnel will administer medications unless patient can safely administer themselves.

_____ The patient is **NOT** capable of safely administering their own medications.

_____ The patient is capable of safely administering their own medications.

Vaccination Dates: Flu_____Pneumovax_____Tetanus_____Other_____

Allergies:

Drug_____

Food_____

Diet: _____General _____Special, explain_____

Current Specialized Treatment:

O2_____CPAP / BiPAP Settings_____

Wound Care, Feeding Tube, Colostomy, etc._____

_____

Durable Medical Equipment Use:

_____Crutches _____Cane _____Walker _____Wheelchair _____Other_____

Continence Status:

Urine_____Stool_____

Restrictions:

Does patient have any Restrictions?_____

Are there any Activity Restrictions Inside / Outside of Facility?_____

Patient may leave Facility for Visits: _____ Alone _____Only with Family or Friends

How Frequently should Physician Re-Check patient's Condition?_____

_____

*Please Initial BOTH Orders:

_____I have examined the above patient & certify that he/she is **Free From Communicable Disease, including active TB and COVID (WE NEED NEGATIVE COVID TEST WITHIN 5 DAYS)**

_____ **Admit Order:** I order Admission to Congregational Home **Skilled Nursing Facility.**

If Applicable, Please Initial Other Orders:

_____I order Admit to **Hospice** Care at Congregational Home

_____I order **Therapy** Eval & Treat at Congregational Home **(Can't receive Therapy if on Hospice):**

_____Physical Therapy _____Occupational Therapy _____Speech Therapy

Will You Be Following the Patient's Care at Congregational Home?

_____**NO, I will NOT be the Attending Primary Care Physician for this patient** while he/she is at Congregational Home. Please assign a facility attending primary care physician.

_____**YES, I will be the Attending Primary Care Physician for this patient** while he/she is at Congregational Home. I will follow patient's care while at the facility, sign facility orders & take facility phone calls 24 hours a day. **In accordance with Skilled Nursing Facility regulations, I will conduct Routine Visits with the patient Every 30 Days**

_____I will **Not** come to Congregational Home to see patient; patient will have to come to my clinic.

_____I will come to Congregational Home to see patient.

SIGNATURE_____Date_____

(Must be Signed by PHYSICIAN, Not PA, NP or RN)

Print Name of Physician signing this form_____

Clinic Address_____

_____Clinic Phone#_____

If you will be Following the Patient's Care at Congregational Home, please provide Additional Physician Information:

Pager#_____Answering Service#_____Fax#_____

Mobile#_____Home#_____

What Hospitals do you utilize?_____

Name of Covering Physician when you are Unavailable_____

Covering Physician Clinic Phone#_____

Pager#_____Answering Service#_____Fax#_____

Mobile#_____Home#_____