

**Patient Name:** \_\_\_\_\_ **Admit to RCU On** \_\_\_\_\_ **(Date)**

**Under the care of: Attending Physician:** \_\_\_\_\_ **CONSULTANTS:**

**Admitting/Primary Diagnosis (es):** \_\_\_\_\_

**SURGERY & DATE:** \_\_\_\_\_

**Secondary Diagnoses:** \_\_\_\_\_

**CODE STATUS:**  FULL CODE  NO CODE

**OTHER INSTRUCTIONS:**

The H & P on admit is essentially the same as one done on \_\_\_\_\_  
Except for the following changes: \_\_\_\_\_

**PHYSICIAN'S PLAN OF CARE:**

Estimated Length of Stay: \_\_\_\_\_

Expected Discharge Destination: \_\_\_\_\_

Restorative/Rehab Potential:  Excellent  Good  Fair  
 Poor  None

**Pt informed of Diagnoses?**  Yes  No

If no, why not? \_\_\_\_\_

**Is patient able to make healthcare decisions?**  Yes  No

If no, why not? \_\_\_\_\_

**REHAB/ORTHO ORDERS:**

**Per Title 22 all residents will be screened by PT/OT/ST.**

\_\_\_\_\_ **COMPREHENSIVE REHAB SERVICES (PT/OT/ST)** for Functional Independence including, Mobility, ADLs, and Therapeutic Exercises 1-2x/day 5-7 times per week X 4 weeks as patient tolerates. *ST if indicated* at 3-5x/week x4 weeks for functional communication/swallow retraining. Modify diet textures/consistencies as recommended by speech therapy Patient/Family/Caregiver education and consultation, PRN.

**Please specify if other therapy orders are indicated:** \_\_\_\_\_

**WEIGHT BEARING STATUS:** \_\_\_\_\_ **PRECAUTIONS:** \_\_\_\_\_

**KNEE REPLACEMENT: CPM PARAMETERS:** \_\_\_\_\_ **Degrees X** \_\_\_\_\_ **Hrs/day**

**MOBILITY/ACTIVITY:**  Bedrest  Chair  Ambulate as tolerated  PROGRESS AS TOLERATED

\_\_\_\_\_ **THIGH HIGH TED HOSE:** Remove 1/2 hour each shift. **D/C WHEN AMBULATING** \_\_\_\_\_ **FEET.**

\_\_\_\_\_ **SEQUENTIAL STOCKINGS** (If not receiving anticoagulation): **D/C WHEN AMBULATING** \_\_\_\_\_ **FEET.**

\_\_\_\_\_ Change Dry Sterile Dressing to  Left  Right hip incision QD & prn soiling/dislodgment until staples/sutures d/ced.

\_\_\_\_\_ D/C Staples/Sutures on \_\_\_\_\_ OR \_\_\_\_\_. Apply tincture of benzoin and steri-strips.

\_\_\_\_\_ Cryotherapy to affected areas Q 2 hrs x 20 min. as needed.

**MAY SHOWER ON OR AFTER:** \_\_\_\_\_

\_\_\_\_\_ **TB SCREENING:** PPD of 5 TU (0.1ml) Intradermally X 1, Read in 72 hours. Then if results are negative, give a PPD 5TU (0.1ml) Intradermally x 1 in 3 weeks. Chest x rays are no longer sufficient for TB testing in RCU. (per State Title 22, Section 72523).

**DIET:**  Regular  Mechanical/Soft  Dysphagia Puree(stroke)  Diabetic

Low Sodium  Gms Other: \_\_\_\_\_

**Nutritional supplements** TID Other: \_\_\_\_\_

**OXYGEN ORDERS:** Give oxygen at \_\_\_\_\_ Liter/minute via \_\_\_\_\_ Nasal Cannula  Other (specify): \_\_\_\_\_

May increase Oxygen up to \_\_\_\_\_ Liters/Minute to keep Oxygen Saturation between \_\_\_\_\_% and \_\_\_\_\_%

Notify physician if Oxygen Saturation is \_\_\_\_\_% with maximum allowed Oxygen

**SKIN/WOUND ORDERS:** \_\_\_\_\_

**FOLEY CATHETER** \_\_\_\_\_ Fr \_\_\_\_\_ cc balloon replace PRN clogging/dislodging irrigate PRN clogging with 60 ml NS. Attempt D/C on \_\_\_\_\_. May reinsert PRN if no void after 6 hrs of bladder scan greater 250ml.

**OTHER ORDERS/LABS:** \_\_\_\_\_



**Dominican Hospital**

**CHW**

**Restorative Care Unit  
STANDARD & ORTHO**

**ADMISSION ORDERS Page 1 of 2**

1616 (3/05)

WHITE - RCU CHART

CANARY - ACUTE CHART

<b>ALLERGIES:</b> ___ NKA	<b>Medication</b> _____	<b>Reaction</b> _____	<b>Medication</b> _____	<b>Reaction</b> _____
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**MEDICATION THERAPY (Check only where appropriate)**

**The medications, by indication, listed below are recommended, in part, as preferred agents for the geriatric patient.**  
Arch Intern Med. 2003; 163 (22): 2716-24.

<p align="center"><b>PAIN MEDICATIONS:</b></p> <p>___ Tylenol 650mg Q4 hrs prn mild pain X _____ days</p> <p>___ Vicodin (hydrocodone) 5mg/500mg APAP 1 tablet PO Q4hr PRN pain score ≤ 3 or breakthrough pain X _____ days</p> <p>___ Vicodin (hydrocodone) 7.5mg/500mg APAP 1 tablet PO Q4hr PRN pain score ≥ 4 or breakthrough pain X _____ days</p> <p>___ Fentanyl patch 25 mcg topically Q3 days X _____ doses</p> <p><u>If duration left blank, auto stop date will be 14 days</u> *Do not exceed 4 gms acetaminophen per day.</p>	<p align="center"><b>BOWEL MEDICATIONS:</b></p> <p>___ Docusate Sodium 250 mg QD x 45 days @ 1800</p> <p>___ Senokot Tabs 2 q hs prn constipation x 45 days</p> <p>___ Dulcolax Sup 1 PR QD prn constipation if no relief from Senokot in 8 hours x 45 days</p> <p>___ Fleets enema 1 PR QD prn if suppository ineffective</p>
<p align="center"><b>ANTICOAGULATION:</b></p> <p>___ Enoxaparin (Lovenox) 40 mg Subcutaneously once daily X _____ days</p> <p>___ Aspirin 325 mg PO once daily X _____ days</p> <p>___ Heparin 5000 units Subcutaneously Q 12 hrs X _____ days</p> <p>___ Warfarin _____ mg Q _____ X 45 days. PT/INR twice per week (Monday &amp; Thursday) X 2weeks, then once weekly (Monday) will be automatically ordered on all warfarin patients.</p> <p>Target INR = _____</p>	<p align="center"><b>IRON SUPPLEMENT</b></p> <p>___ Iron Sulfate 300 mg PO QD X _____ days @ 1200</p>
<p align="center"><b>FOR SLEEP:</b></p> <p>___ Temazepam (Restoril) 7.5mg PO qhs prn sleep X 7 days, MR X1 in 1hr</p> <p>___ Zolpidem (Ambien) 5mg PO QHS prn sleep X 7 days, MR X1 in 1hr</p>	<p align="center"><b>DECUBITUS PROTOCOL/SUPPLEMENTS:</b></p> <p>___ Vitamin C 500 mg PO BID X 45 days.</p> <p>___ MVI w/ minerals 1 tablet PO once daily X 45 days.</p> <p>___ Zinc Sulfate 220 mg PO once daily X 45 days.</p>
<p align="center"><b>FOR DEPRESSION:</b></p> <p>___ Escitalopram (Lexpro) 10mg PO QAM X 45 days</p> <p>___ Trazodone (Desyrel) 25mg PO QHS X 45 days</p>	<p align="center"><b>ANTI-INFLAMMATORIES:</b></p> <p>___ Ibuprofen (Motrin) 400mg PO TID X _____ days</p> <p>___ Naproxen (Naprosyn) 500mg PO BID X _____ days</p> <p align="center"><b>Give with meals and adequate amount of fluids</b></p>
<p><b>Medications Not Ordered From Above Require Documented Clinical Justification (Title 22 DHS reg)</b></p>	
<p><input type="checkbox"/> Diabetic Orders per separate Standard Diabetic Physician Orders (MD to fill out and authenticate)</p>	

**Other orders:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_


**MAY PARTICIPATE IN ACTIVITIES NOT IN CONFLICT WITH TREATMENT PLAN.**  
**COMMUNICATION SYSTEM PREFERRED (NON-EMERGENT):**  Phone Call  Fax

I certify that post-hospital ECF services are required on an inpatient basis because of the patient's need for skilled nursing care on a continuing basis for the conditions for which he/she was receiving inpatient hospital services prior to his/her transfer to ECF. Continue above order for 45 days unless otherwise specified.

**RCU ADMIT:** \_\_\_\_\_ **DATE/TIME:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE/TIME:** \_\_\_\_\_

**ORDERS NOTED BY:** \_\_\_\_\_ **DATE/TIME:** \_\_\_\_\_


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