Winter Growth

# Assisted Living

## Frequently Asked Questions

Winter Growth believes in meeting the individual needs of our residents without unexpected fees. Our cost of care is **all inclusive** and is based on each resident's level of care as determined by an assessment tool provided by the State of Maryland.

**Do residents have to share a bedroom?** We offer **only** private rooms.

**Are bathrooms shared or private?** National Institute on Aging (NIA) researchers have determined that more than a third of seniors over the age of 65 slip and fall each year and that 80% of those falls occur in the bathroom. Winter Growth specifically designed its living space to incorporate shared restrooms located just steps away from individuals' rooms. This design makes it easier for caregivers to be aware of when residents need assistance and aids in preventing fall injuries that so often occur in private bathrooms.

**How many staff will be in the building?** We have one staff member for every eight residents during the day and evening hours. In the overnight hours there is a minimum of one awake staff member based on the current number of residents and their care needs.

**When does a nurse visit?** A registered nurse and/or LPN is on the premises a minimum of five days a week.

**What happens during the day?** Winter Growth has an active, on-site adult day program that is tailored to meet the interests and needs of the residents. Monday – Friday, the fun starts at 9am and ends at 3pm with fitness, memory, and social programs including musical entertainment and dancing, spirited discussion groups, painting, exercise classes, gardening, shopping and recreational outings, intergenerational activities with scout and school groups, and so much more.

**What additional fees are charged if a resident needs to be dressed or fed?** There are no additional fees for services. Residents are charged one of two all-inclusive fees based on their level of care, as determined by an assessment tool provided by the State of Maryland.

**Winter Growth Assisted Living**
Columbia: 5460/5466 Ruth Keeton Way
Olney: 18110 Prince Philip Drive

**Do you charge a community fee?** No. Unlike other assisted living facilities, we purposefully choose not to charge a community fee as Winter Growth recognizes the potential financial hardship it can cause families.

**Do I have to bring my own furniture?** While you are welcome to bring your own, Winter Growth can also provide a bed, dresser, and nightstand.

**What are visiting hours?** You can visit any time of day, however, if you are visiting late at night please be respectful of other residents who may be sleeping.

**Can I bring my pet?** Dog, cats, and other pets are welcome as long as your family member can take care of the pet independently and the pet can get along with other animals in the building.

**Do you provide transportation for medical appointments?** We do have transportation available for a modest fee during limited hours Monday-Friday.

**Do you provide phone, internet, and cable service?** Winter Growth does not provide these services. We do have a phone available for residents, community television, and WiFi throughout the building. Families are welcome to make arrangements for these services through a 3rd party provider.

**My family member has memory issues. How safe is your facility?** Our community offers a secure environment that reduces elopement risks and is conducive to healthy wandering both inside our building and outside in our enclosed garden area. While residents are free to walk and explore, staff is always watching to ensure that residents are safe.

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Winter Growth

# Assisted Living
## Move-In Checklist

Winter Growth is excited to have you join our family. Please review the following to ensure a smooth transition.

## PRIOR TO MOVE-IN DAY STAFF WILL NEED:

- Application for admission
- Documentation of income
- Power of Attorney Documentation
- Completed Assessment from your physician
- Proof you are free from tuberculosis; this can be verified by a PPD or chest x-ray
- Completed MOLST form signed by your physician
- Resident Rental & Service Agreement
- Pharmacy Services Agreement
- Media release
- HIPAA Acknowledgement
- Meal benefit form
- Payment for first month (prorated as needed)
- Enrollment Deposit

## ON OR BEFORE MOVE-IN DAY STAFF WILL NEED:

- Funeral arrangements (included in Application)
- Copy of ALL Medical cards (Medicare, Medicaid, Medicare Part D-Prescription coverage)
- Supplemental Insurance Information

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# Housing Application

Winter Growth

Name: _____ Telephone: _____

Address: _____

Date of Birth: _____ US Citizen: ❑ Yes ❑ No

Ethnicity: ❑ Asian ❑African American ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Pacific Islander ❑ Other ❑ Prefer not to answer

Primary Language(s): _____

If other than English, is applicant able to communicate in English? ❑ Yes ❑ No

Additional Information regarding communication: _____

Health Insurance Company: _____ Number: _____

Medicare: _____ Medicaid: _____ (if applicable)

Currently Lives: ❑ Alone ❑ With Family Member_____ ❑ Assisted Living/Group Home

**First Person to be Notified in Emergency (Relationship:_____)**
**Check if: ❑ Power of Attorney ❑ DPoA Healthcare ❑ Guardian**

Name: _____ Address: _____

Phone: (H)_____ (W) _____ (C) _____

Email address:_____

**Alternate Person to be Notified in Emergency (Relationship:_____)**
**Check if: ❑ Power of Attorney ❑ DPoA Healthcare ❑ Guardian**

Name: _____ Address: _____

Phone: (H)_____ (W) _____ (C) _____

Email address:_____

**If applicant has Advanced Directives for healthcare, please submit a copy. A completed MOLST form is a requirement for all assisted living residents in the state of Maryland.**

Attending Physician: _____ Phone: _____ Fax: _____

Address_____

Specialist: _____ Phone: _____ Fax: _____

Address_____

**Personal History**

***The information in this section will help us to develop a truly individual person-centered activity program for your loved one. We appreciate your sharing his or her uniqueness with us.***

Place of Birth: _____ Grew Up: _____

Considers Home State/Country to Be: _____

Ever Lived Abroad: ❑ No ❑ Yes (Where? _____)

Marital Status**:** ❑ Single ❑ Widowed ❑ Married ❑ Separated ❑ Divorced How long?_____

**Education/Work History:**

❑ Did Not Complete High School ❑ Completed High School / GED ❑ College ❑ Post Graduate

Occupation(s) most important listed first:_____

**Military Service:** Is applicant a veteran? ❑ Yes ❑ No Was spouse a veteran? ❑ Yes ❑ No
**Branch?** ❑ Army ❑ Navy ❑ Air Corp/Air Force ❑ Marines ❑ Coast Guard Rank: _____
**Wars Served In:** ❑ WWII ❑ Korean ❑ Vietnam ❑ Middle East

**Interests/Hobbies:** *(**CHECK** all that apply to the Past; **CIRCLE** all that apply to Current):*
❑Arts/Crafts ❑Babies/Children ❑Being Read To ❑Board/Card Games ❑Cooking ❑Dancing
❑Discussion Groups ❑Educational Programs ❑Field Trips ❑Lawn Games ❑Music/Sing-A-Long
❑Music/Listening ❑Needlework ❑Pet Cats ❑Pet Dogs ❑Philosophy ❑Physical Fitness
❑Reading ❑Religion ❑Reminiscing ❑Shopping ❑Travel Logs ❑Sports ❑Writing
❑Other (Please List) _____

**Spiritual Tradition(s)** ❑Buddhism ❑Christianity ❑Hinduism ❑Islam ❑Judaism ❑Non-Specified
❑Other _____ ❑Currently attends services ❑Previously attended services

**Life Traumas/ Tragedies about Which We Should be Aware:** _____

_____

**Children of Applicant:** **Address:** **Home Phone:** **Work Phone:**

1._____

2._____

3._____

Grandchildren_____

Great Grandchildren_____

Additional Family Information_____

**Medical History**

**Experiences (*If applicable please explain):***

Anxiety: _____

Depression: _____

**Challenging Behaviors?** (*verbally inappropriate, disruptive, combative, etc.*)

_____

_____

If yes, what makes it better?_____

**Briefly describe RECENT (within past 6 mths) changes in health or behavioral status, hospitalizations, falls, etc.:**

_____

_____

**Briefly describe any PAST illnesses or chronic conditions (including hospitalizations):**

_____

_____

**Allergies** (Include medication, food, and environment. Add reactions, such as rash, if applicable.):

_____

_____

_____

****Diabetic**: ❑ No If Yes, ❑ Diet Controlled ☐ Medication Controlled ☐ Insulin Dependent

## Nutritional Needs

**Height in inches**: _____ **Weight in lbs**: _____

**Concerns about weight change gain or loss in past 6 months**? ❑ Yes ❑ No

If yes, please explain:_____

**Concerns about dehydration?** ❑ Yes ❑ No

If yes, please explain:_____

**Does applicant have medical or dental conditions affecting** (check all that apply):
 Chewing ❑ Swallowing ❑ Eating ❑ Pocketing food ❑ Gastronomy Tube Fed

**Note any special therapeutic diet** (e.g. sodium restricted, renal, calorie, or sugar restricted):
 Regular ❑ No Added Salt ❑ No Concentrated Sweets ❑ Renal ❑ No Pork ❑ No Shellfish
❑ Vegetarian ❑ Mechanical Soft ❑ Thick Liquids ❑ Pureed

## Functional Needs

**Does the applicant experience incontinence?**
Bowel: _____

Bladder: _____

**Does the applicant have problems with:**
LEFT Arm _____Adaptive Equipment_____
RIGHT Arm _____Adaptive Equipment_____
LEFT Hand _____Adaptive Equipment_____
RIGHT Hand _____Adaptive Equipment_____
LEFT Leg _____Adaptive Equipment_____
RIGHT Leg _____Adaptive Equipment_____

**Does the individual have any of the following:** ❑Gait Problem ❑Impaired Balance ❑Foot Deformity

❑Assistive Devices for Walking (Please Explain)_____

**Skin condition(s):**
❑Jaundice ❑Rash ❑Scar ❑Abrasion ❑Laceration ❑Decubitus ❑Burn ❑Erythemous ❑Petechia

**Hearing condition:** ❑Adequate ❑Poor ❑Deaf ❑Uses corrective aid (__Left Ear +/or __Right Ear)

**Vision:** ❑ Adequate ❑ Poor
Uses corrective lenses: ❑ Glasses ❑ Contacts
Is blind (check all that apply): ❑ Right Eye ❑ Left Eye

**Is there a history of seizures?** ❑ No ❑ Yes Type/Cause (if known)_____
Date of Last Seizure _____

## Daily Living (ADLs)

**Eating:** ❑ Independent
□ Needs assistance (please explain):_____

**Walking:** ❑ Independent
□ Needs assistance (please explain):_____
Adaptive Equipment: ❑ Cane ❑ 4 Pronged Cane ❑ Walker ❑ Wheelchair: __Manual __Motorized

**Move In/Out of Bed, Chair or Toilet:** ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____
Adaptive Equipment: ❑ Lift ❑ Slide Board ❑ Trapeze ❑ Other ❑ Multiple

**Use of Stairs:** ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____

**Toileting:** ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____

**Bathing:** ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____

**Grooming (teeth, make-up, shaving, hair):** ☐Independent ☐Unable

□ Needs assistance (please explain):_____ If dentures: ❑ Partial ❑ Upper ❑ Lower

**Getting Dressed/Changing Clothes:** ❑ Independent ❑ Unable

□ Needs assistance (please explain):_____

**Daily Living (IADLs)**

**Prepare Light Meal:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Does Light Chores:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Does Shopping:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Ability to Manage Finances:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Transportation:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Resident Uses Telephone:** ❑ Independent ❑ Unable

Needs assistance (please explain):_____

**Sleep Disturbance:** ***If applicable please explain frequency of behavior (occasional, weekly, daily)***

Unable to sleep or agitated at night _____

Average number of hours sleeps at night _____

Frequently falls asleep during day _____

Hours a day nap_____

**Wanders** ***If applicable please explain frequency of behavior (occasional, weekly, daily)***

Persistent moving/walking about without purpose _____

Looks for non-existent place (former house /bus) _____

Actively tries to leave house _____

Wanders during day _____

Wanders in evening &/or night _____

**Eating patterns and food preferences** *(check all that apply)*

□ Eats full meals ❑ Eats only two meals ❑ Eats small portions

□ Finger foods ❑ Eats only **what** he/she wants, but maintains weight
□ Supplements (type)_____
Favorite food: _____
Strong dislikes: _____

**Current Daily Routine**
Usual time up in the morning: _____
Is the applicant easy or difficult to wake? (circle one)
Usual bedtime: _____
Preferred time to shower/bathe: _____
Meal time preferences: _____
Preferred evening/after dinner activities (Eg. television, crossword, reading, etc.): _____
_____

**State of Maryland Requires Burial Arrangements**

Per Assisted Living regulations, Winter Growth Inc. is required by the State of Maryland to have information on burial arrangements for each resident.

**Please provide the following information for**:_____

**Funeral Home/Director**

Name: _____ Phone: _____

Address: _____

**Have financial arrangements for burial been made?** ❑ Yes ❑ No

**What are the name, address, telephone number and relationship of the person who has agreed to assume funeral and burial responsibility?**

Name: _____ Relationship: _____

Address: _____

Phone: _____ Cell: _____

**If no funeral arrangements have been made for _____, please state that below for our records.**

_____

_____

## Income Verification

**Name:_____**

**In addition to completing the income and assets charts *please attach acceptable verification* for each listed item (Social Security awards letter, pension statement, bank statement, etc.)**

| Type of Income (detail) | Annual | Monthly |
|---|---|---|
| Social Security | $ | $ |
| Pension | | |
| Other: | | |
| Other: | | |
| Other: | | |
| Other: | | |
| TOTAL **(I)** | $ | $ |

If total monthly income will not meet the anticipated monthly housing fee explain in detail how balance of fee will be paid.

## Assets

Assets include savings accounts, dividends, net rental income, stocks, bonds, CD's, Money Market Funds, equity in real property, and the market value of all other capital investments.

| Individual Assets | Cash Value of Assets | Yearly Income from Assets |
|---|---|---|
| | $ | $ |
| | | |
| | | |
| | | |
| | | |
| TOTAL | $ | $ |
| Co-owned Assets | Cash Value of Assets | Yearly Income from Assets |
| | | |
| | | |
| | | |
| TOTAL | $ | $<br>(II) |

**PRIVACY ACT STATEMENT**

The information on this form is being collected to determine an applicant's ability to pay all fees associated with residing in one of Winter Growth's Assisted Housing programs. The information may be released to appropriate Federal, State and local agencies when relevant to civil, criminal, or regulatory investigations or prosecutions. In addition, representatives of any institution in conjunction with maintaining funding eligibility for one or more housing programs may review the information. Failure to provide any of the information may result in a delay or rejection of your eligibility approval.

**APPLICANT'S CERTIFICATION**

I, as Power of Attorney and/or Guarantor for the above referenced resident, certify that the information set forth on this form is true and complete to the best of my knowledge and belief and is given under the penalty of perjury. Failure to provide full and accurate information could result in termination of housing agreement.

_____ _____

Signature Date

_____

Print Name

_____ _____

Winter Growth Representative and Title Date

(To be completed by Winter Growth staff)

**Move-in Date:_____Unit Number_____**

If total Cash Value of Assets exceeds $5,000:

Income from Assets:
Total Cash Value of Assets **(II)**_____ x .02 (HUD passbook rate) =_____**(III)**

| Medical Expenses (detail) | Annual |
|---|---|
| Assisted Living (less $5,040) | $ |
| Medical Day Care | |
| Other: | |
| Other: | |
| Other: | |
| TOTAL-**(IV)** | $ |

**Total Annual Income** _____
(I + III) – (IV)

Current Income Limit per State of Maryland-_____ as of _____

_____ _____
Winter Growth Representative and Title Date

Resident Name _____ Date Completed _____

Date of Birth _____

# Health Care Practitioner Physical Assessment Form

This form is to be completed by a primary physician, certified nurse practitioner, registered nurse, certified nurse-midwife or physician assistant. Questions noted with an asterisk are "triggers" for awake overnight staff.

Please note the following before filling out this form: Under Maryland regulations an assisted living program may not provide services to a resident who, at the time of initial admission, as established by the initial assessment, requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; or (6) Treatment for a disease or condition that requires more than contact isolation. An exception to the conditions listed above is provided for residents who are under the care of a licensed general hospice program.

1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)?

(Check one) ☐ Yes ☐ No If "No," then indicate the communicable disease: _____

Which tests were done to verify the resident is free from active TB?

PPD Date: _____ Result:_____mm

Chest X-Ray (if PPD positive or unable to administer a PPD) Date: _____ Result_____



**Questions? Contact Winter Growth:**
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)

Resident Name _____ Date Completed _____

Date of Birth _____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

(a) Substance: OTC, non-prescription medication abuse or misuse
1. Recent (within the last 6 months) ☐ Yes ☐ No
2. History ☐ Yes ☐ No

(b) Abuse or misuse of prescription medication or herbal supplements
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(c) History of non-compliance with prescribed medication
1. Currently ☐ Yes ☐ No
2. Recent (within the last 6 months) ☐ Yes ☐ No

(d) Describe misuse or abuse: _____
_____

6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): ☐ orthostatic hypotension ☐ osteoporosis ☐ gait problem ☐ impaired balance ☐ confusion ☐ Parkinsonism ☐ foot deformity ☐ pain ☐ assistive devices ☐ other (explain)

_____

7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders. _____

_____

8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing: Left ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid
Right ear: ☐ Adequate ☐ Poor ☐ Deaf ☐ Uses corrective aid

(b) Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind (check all that apply) - ☐ R ☐ L

(c) Temperature Sensitivity: ☐ Normal ☐ Decreased sensation to: ☐ Heat ☐ Cold

9. Current Nutritional Status. Height _____inches Weight _____lbs.

(a) Any weight change (gain or loss) in the past 6 months? ☐ Yes ☐ No
(b) How much weight change? _____lbs. in the past _____ months (check one) ☐ Gain ☐ Loss
(c) Monitoring necessary? (Check one.) ☐ Yes ☐ No
If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(d) Is there evidence of malnutrition or risk for undernutrition? ☐ Yes ☐ No
(e)* Is there evidence of dehydration or a risk for dehydration? ☐ Yes ☐ No
(f) Monitoring of nutrition or hydration status necessary? ☐ Yes ☐ No
If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur: _____
_____

(g) Does the resident have medical or dental conditions affecting: (Check all that apply)
☐ Chewing ☐ Swallowing ☐ Eating ☐ Pocketing food ☐ Tube feeding

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted): _____
_____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids): _____
_____

(j) Is there a need for assistive devices with eating (If yes, check all that apply): ☐ Yes ☐ No
☐ Weighted spoon or built up fork ☐ Plate guard ☐ Special cup/glass

(k) Monitoring necessary? (Check one.) ☐ Yes ☐ No
If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur:
_____



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(301) 774-7501 (Olney)

Resident Name _____ Date Completed _____

Date of Birth _____

10.* Cognitive/Behavioral Status.

(a)* Is there evidence of dementia? (Check one.) ☐ Yes ☐ No

(b) Has the resident undergone an evaluation for dementia? ☐ Yes ☐ No

(c)* Diagnosis (cause(s) of dementia): ☐ Alzheimer's Disease ☐ Multi-infarct/Vascular ☐ Parkinson's Disease ☐ Other

(d) Mini-Mental Status Exam (if tested) Date _____ Score _____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

| Item 10(e) | A | B* | C* | D* | Comments |
|---|---|---|---|---|---|
| **Cognition** | | | | | |
| I. Disorientation | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| II. Impaired recall (recent/distant events) | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| III. Impaired judgment | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| IV. Hallucinations | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| V. Delusions | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| **Communication** | | | | | |
| VI. Receptive/expressive aphasia | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| **Mood and Emotions** | | | | | |
| VII. Anxiety | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| VIII. Depression | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| **Behaviors** | | | | | |
| IX. Unsafe behaviors | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| X. Dangerous to self or others | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |
| XI. Agitation (Describe behaviors in comments section) | ☐ Never | ☐ Occasional | ☐ Regular | ☐ Continuous | |

10(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

☐ (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment).

☐ (b) Probably can make limited decisions that require simple understanding.

☐ (c) Probably can express agreement with decisions proposed by someone else.

☐ (d) Cannot effectively participate in any kind of health care decision-making.

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

☐ (a) Independently without assistance

☐ (b) Can do so with physical assistance, reminders, or supervision only

☐ (c) Need to have medications administered by someone else

_____ _____

Print Name Date

_____

Signature of Health Care Practitioner

Resident Name _____ Date Completed _____

Date of Birth _____

## PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

| 12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements.<br><br>Include dosage route (p.o., etc.), frequency, duration (if limited). | 12(b) All related diagnoses, problems, conditions.<br><br>Please include all diagnoses that are currently being treated by this medication. | 12(c) Treatments (include frequency & any instructions about when to notify the physician).<br><br>Please link diagnosis, condition or problem as noted in prior sections. | 12(d) Related testing or monitoring.<br><br>Include frequency & any instructions to notify physician. |
|---|---|---|---|
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Prescriber's Signature _____ Date _____

Office Address _____ Phone _____



**Questions? Contact Winter Growth:**
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)

Resident Name _____ Date Completed _____

Date of Birth _____

**PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION**

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is ***not*** to be crushed please indicate.

| 12(a) Medication(s). Including PRN, OTC, herbal, & dietary supplements.<br><br>Include dosage route (p.o., etc.), frequency, duration (if limited). | 12(b) All related diagnoses, problems, conditions.<br><br>Please include all diagnoses that are currently being treated by this medication. | 12(c) Treatments (include frequency & any instructions about when to notify the physician).<br><br>Please link diagnosis, condition or problem as noted in prior sections. | 12(d) Related testing or monitoring.<br><br>Include frequency & any instructions to notify physician. |
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Prescriber's Signature _____ Date _____

Office Address _____ Phone _____