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

Winter Growth Assisted Living
Columbia: 5460/5466 Ruth Keeton Way
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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	$	$ (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 ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation.
An exception is provided for residents who are under the care of a licensed general hospice program.

Resident:	DOB: - -	Assessment Date: - -
Primary Spoken Language:	☐ Male ☐ Female	

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.
Test to verify the resident is free from active TB *(completed no more than 1 year prior to admission)*:
PPD Date: - - Result: mm OR Chest X-Ray Date: - - Result:
Does the resident have any active reportable airborne communicable diseases? ☐ No ☐ Yes
(specify)

Vital Signs.
BP: / Pulse: Resp: T: °F Height: ft in Weight: lbs
Pain: ☐ No ☐ Yes (specify site, cause, & treatment)

Neuro. Alert & oriented to: ☐ Person ☐ Place ☐ Time
Answers questions: ☐ Readily ☐ Slowly ☐ Inappropriately ☐ No response
Memory: ☐ Adequate ☐ Forgetful – needs reminders ☐ Significant loss – must be directed
Is there evidence of dementia? ☐ No ☐ Yes (cause)
Cognitive status exam completed? ☐ No ☐ Yes (results)
Sensation: ☐ Intact ☐ Diminished/absent (describe below)
Sleep aids: ☐ No ☐ Yes (describe below) Seizures: ☐ No ☐ Yes (describe below)
Comments:

Eyes, Ears, & Throat. ☐ Own teeth ☐ Dentures Dental hygiene: ☐ Good ☐ Fair ☐ Poor
Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind - ☐ R ☐ L
Hearing: ☐ Adequate ☐ Poor ☐ Uses corrective aid ☐ Deaf - ☐ R ☐ L
Comments:

Resident:	DOB: - -	Assessment Date: - -

Musculoskeletal. ROM: ☐ Full ☒ Limited
Mobility: ☐ Normal ☐ Impaired → Assistive devices: ☐ No ☐ Yes (describe below)
Motor development: ☐ Head control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors
ADLs: (S=self; A=assist; T=total) Eating: S Bathing: S Dressing: S
Is the resident at an increased risk of falling or injury? ☐ No ☐ Yes (explain below)
Comments:

Skin. Intact: ☐ Yes ☐ No (if no, a wound assessment **must** be completed)
☐ Normal ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other
Any skin conditions requiring treatment or monitoring? ☐ No ☐ Yes (describe condition & treatment)

Respiratory. Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored
Breath sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)
Shortness of breath: ☐ No ☐ Yes (indicate triggers below)
Respiratory treatments: ☐ None ☐ Oxygen ☐ Aerosol/nebulizer ☐ CPAP/BIPAP
Comments:

Circulatory. History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension
Pulse: ☐ Regular ☐ Irregular Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes
Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic
Comments:

Diet/Nutrition. ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets
☐ Mechanical soft ☐ Pureed ☐ Other (explain below) ☐ Supplements (explain below)
Is there any condition which may impair chewing, eating, or swallowing? ☐ No ☐ Yes (explain below)
Is there evidence of or a risk for malnutrition or dehydration? ☐ No ☐ Yes (explain below)
Is any nutritional/fluid monitoring necessary? ☐ No ☐ Yes (describe type/frequency below)
Are assistive devices needed? ☒ No ☐ Yes (explain below)
Mucous membranes: ☐ Moist ☐ Dry Skin turgor: ☐ Good ☐ Fair ☐ Poor
Comments:

Elimination.
Bowel sounds present: ☐ Yes ☐ No Constipation: ☐ No ☐ Yes Ostomies: ☐ No ☐ Yes
Bladder: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
Bowel: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
(If any incontinence, describe management techniques)
Comments:

Additional Services Required. ☐ No ☐ Yes (indicate type, frequency, & reason)
☐ Physical therapy ☐ Home health ☐ Private duty ☐ Hospice ☐ Nursing home care ☐ Other
Comments:

Resident:	DOB: - -	Assessment Date: - -

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? ☒ No ☐ Yes (explain)
Comments:

Psychosocial. **KEY**: ***N*** *= Never* ***O*** *= Occasional* ***R*** *= Regular* ***C*** *= Continuous*					
	N	**O**	**R**	**C**	**Comments**
Receptive/Expressive Aphasia	☐	☐	☐	☐	
Wanders	☐	☐	☐	☐	
Depressed	☐	☐	☐	☐	
Anxious	☐	☐	☐	☐	
Agitated	☐	☐	☐	☐	
Disturbed Sleep	☐	☐	☐	☐	
Resists Care	☐	☐	☐	☐	
Disruptive Behavior	☐	☐	☐	☐	
Impaired Judgment	☐	☐	☐	☐	
Unsafe Behaviors	☐	☐	☐	☐	
Hallucinations	☐	☐	☐	☐	
Delusions	☐	☐	☐	☐	
Aggression	☐	☐	☐	☐	
Dangerous to Self or Others	☐	☐	☐	☐	*(if response is anything other than never, explain)*

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: ☐ Yes ☐ No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:

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

☐ Probably can make limited decisions that require simple understanding

☐ Probably can express agreement with decisions proposed by someone else

☐ Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:

☐ Independently without assistance

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

☐ Needs to have medications administered by someone else

General Comments.

Resident:	DOB: - -	Assessment Date: - -

Health Care Practitioner's Signature: _____ Date: - -

Print Name & Title:

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? ☐ Yes ☐ No (explain below)

Were any discrepancies identified? ☐ No ☐ Yes (explain below)

Are medications stored appropriately? ☐ Yes ☐ No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below)

Have arrangements been made to obtain ordered labs? ☐ Yes ☐ No (explain below)

Is the resident taking any high risk drugs? ☐ No ☐ Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? ☐ Yes ☐ N/A ☐ No (explain below)

Is the environment safe for the resident? ☐ Yes ☐ No (explain below)
(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: - -

Print Name:

Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.

Six-Month Review *Conducted By:*

Signature: _____ *Date:* _____

Print Name & Title: _____

Resident Name:	DOB: mm-dd-yy	Date Completed: mm-dd-yy

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all):

MEDICATIONS & TREATMENTS:

List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

Medication/Treatment Name	*Dose*	*Route*	*Frequency*	*Reason for Giving*	*Related Monitoring & Testing (if any)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					

Resident Name:			DOB: mm-dd-yy		Date Completed: mm-dd-yy
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

Lab Test	*Reason*	*Frequency*
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders?

Prescriber's Signature: _____ Date: _____

Office Address: Phone: - -