Alpine House
assisted living facilities

Location: _____
Phone: _____
Fax: _____

Admission Orders

	Today's Date:	
Resident:	Age:	DOB:
	Expected Date of Admission:	

GENERAL ORDERS			**Comments/Instructions**
Resident may leave facility un-escorted?	**Yes**	**No**	
Resident is capable of self-administering medications?	**Yes**	**No**	
Resident is permitted to consume alcohol?	**Yes**	**No**	
Resident's current medications require crushing? If yes. List.	**Yes**	**No**	

ROUTINE MEDICATIONS (please use additional sheet/s if required)

Medication	**Strength/Dose/Route/Frequency**

PRN MEDICATIONS (please use additional sheet/s if required)

Please initial next to the statement that best describes this resident:

	My patient can determine and clearly communicate his/her need for prescription and nonprescription PRN medication.
	My patient cannot determine his/her own need for prescription and nonprescription PRN medication, but can clearly communicate his/her symptoms indicating a need for a nonprescription medication.
	My patient cannot determine his/her need for prescription and/or nonprescription PRN medication and cannot communicate his/her symptoms indicating a need for nonprescription medication. (Must contact physician before each dose).

Medication	**Strength/Dose/Route/Frequency**	**Symptom/Reason**	**Max Dose in 24°**

STANDING ORDERS

Please initial all desired orders and complete necessary information. Thank you.

Initials	**Instructions (please complete if blank)**	
	PPD Skin Test	Prior to or within 48 hours upon admission and annually
	Influenza Vaccination	Annually
	Pneumococcal Vaccine	

PHYSICIAN CERTIFICATION: ☐ **RESIDENT MEETS LEVEL OF CARE REQUIREMENTS FOR RESIDENTIAL CARE FACILITY PLACEMENT**

Physician's Signature	Physician's Name	Date