Krishna's Home 514 E. Blacklidge Dr. Tucson, Arizona 85705
Initial Medication/Treatment Plan of Care

Name: _____ **Date:** _____

Primary care provider (PCP) name: _____

The above person wants to be a resident at Krishna's Home Assisted Living. State regulations require we have the following orders from you. Please complete both pages of this form & it.

All known diagnosis:
Food and medication allergies:
Diet (check one) ☐ As tolerated ☐ NAS ☐ NCS ☐ Other:
TB Skin Test (2 Step Preferred) / **Chest X-ray** Date: Result:
Treatments: ☐ None ☐ As listed below:

This person requires oxygen. …… ☐ Yes ☐ No

If yes ☐ PRN ☐ Continuous @ ☐ 2L ☐ 3L ☐ _____ L/min

This person's code status is. …… ☐ DNR ☐ Full Code

This person is diabetic and needs FSBS PRN and …… ☐ Q Week ☐ Daily ☐ 2X Daily ☐ 4X Daily

May we have a flu shot given annually? …… ☐ Yes ☐ No

May we administer a TB Test (PDP) annually? …… ☐ Yes ☐ No

Recommended physician visit schedule: ☐ Annually ☐ Every 6 months ☐ Every 3 month.

☐ Monthly ☐ Other

_____

Vital signs to be taken: …… ☐ Monthly ☐ Weekly ☐ Daily ☐ Other _____

Unable to be weighed because: _____ ☐ Yes ☐ Okay to weigh

May this resident participate in daily range of motion activities? ☐ Yes ☐ No

If no, what are his/her limitations:

_____

Evacuation from the assisted living facility ☐ Will not cause harm ☐ Will cause harm and should not be done.

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I approve the following medication orders for the above-mentioned patient.

Med/Strength	Dose	Route	Frequency	Treats

Discontinue all medications not on the above list. I have examined the person on the date below. I have reviewed and approved this person's medication regime. I hereby authorize All certified caregivers slash managers of Krishna's Home Assisted Living will fill mediset and/or administer all medications and treatments I prescribe for the above mentioned patient whenever the patient is a resident in the home. I do not need to authorize each individual person. I have read and approved the medication policies/procedures and scope of services of Krishna's Home. I also authorized the manager or their designee to act as my agent when taking telephone orders. And faxing orders to the pharmacy of the residents choice.

The person ☐ ambulates ☐ is wheelchair/chair confined per DHS regulations. Krishna's Home Assisted Living can meet the resident's needs, is within their scope of service and based on assessment on the date below, I approve the resident to stay at Krishna's Home.

PCP Name: _____ **Signature:** _____ **Date:** _____