Parkwood

A LIFE CARE SERVICES® COMMUNITY

DIRECT ADMIT

Patient First Name: _____ Last Name: _____

DOB: _____

1. Admit to: Skilled Nursing
2. PCP: _____

   Phone #: _____
3. Primary Diagnosis: _____
4. Allergies: _____
5. Activity:

   □ Ad lib □ Bed rest

   □ Bed rest with bathroom privileges/assistance

   □ Restrictions:

   _____

   _____
6. Diet/Nutrition:

   □ Regular □ Diabetic □ Low sodium □ Soft

   □ Puree □ NPO □ Thickened liquids

   □ Tube feed/Other: _____
7. Advance Directives:

   □ Full code □ Do not resuscitate/Do not intubate

   □ Modified/other: _____
8. Therapy: □ PT □ OT □ ST
9. Wound care:

   Wound care orders attached: □ Yes □ No

   Wound location: _____

   Other instructions/dressing: _____

   _____

   _____
10. Other care:

    □ X-ray: _____

    □ IV fluids: _____

    □ IV meds: _____

    □ RT: _____

    Copy of medications list attached: □ Yes □ No

    To the care of a Facility Physician: □ Yes □ No
11. To the care of:

    Dr./Group _____

    Phone #: _____

Additional Orders:_____

_____

_____

Physician Name (Please Print) : _____ Date: _____

Physician Signature: _____

Phone (817) 354-6556 Fax (817) 533-7110

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