MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
INPATIENT DISCHARGE PLANNING TEAM	NAVHOSPPNCLAINST 6320.62J	11 Feb 2013

LOCAL FORM TITLE *(Optional)*
HOME HEALTH CARE OR HOSPICE ORDERS

Privacy Act Statement: The information on this document is subject to the provisions of the Privacy Act of 1974 (5 U.S.C. 552a)

Date of Discharge: _____ Receiving Agency: _____

Contact: _____ Phone: _____

PATIENT INFORMATION:

Name: _____ DOB: _____

Address: _____

Phone: _____

Family Contact: _____

_____

DIAGNOSES:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

DNR: ☐ YES (attach "Yellow" HRS Form) ☐ NO **LIVING WILL:** ☐ YES ☐ NO

ALLERGIES:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CALL DOCTOR FOR: ☐ Fever ☐ Vomiting ☐ Other: _____

ANAPHYLAXIS PROTOCOL: ☐ 911 ☐ MAINTAIN AIRWAY ☐ 100% O2

LAB WORK*	FREQUENCY	START DATE	STOP DATE
☐ CBC			
☐ BMP			
☐ CMP			
☐ PT			
☐ PTT			
☐ OTHER:			

ENTER LAB ORDERS IN CHCS

Provide copies for: Primary Care Manager, Outpatient Record and Inpatient Record (if applicable) **(CONTINUE ON REVERSE SIDE)**

PRACTITIONER'S NAME	NPI#	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*		HOSPITAL OR MEDICAL FACILITY	STATUS
		DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
		SPONSOR'S NAME	SSN
		RELATIONSHIP TO SPONSOR	

ATTENDING PHYSICIAN INFORMATION (Please Print):

Name: _____ Phone: _____ Beeper: _____

After Hrs Contact: _____ Phone: _____ Beeper: _____

PCM: _____ Phone: _____ Beeper: _____

ORAL / TOPICAL MEDICATIONS Height: _____ Weight: _____

MEDICATION	DOSE/ROUTE	FREQUENCY	START DATE	STOP DATE
1.				
2.				
3.				
4.				
5.				

INTRAVENOUS / INTRAMUSCULAR MEDICATIONS ***** IV MEDS / FLUIDS / FLUSH ORDERS REQUIRE WRITTEN PRESCRIPTION *****

MEDICATION	DOSE/ROUTE	FREQUENCY	START DATE	STOP DATE
1.				
2.				
3.				
4.				
5.				

IV SITE CARE / ORDERS:

SITE: _____ TYPE: _____ DATE IV INSERTED: _____

DRESSING CHG FREQUENCY: _____ ☐ YES ☐ NO

OTHER PATIENT CARE ORDERS:

TUBE CARE:

Type: _____

Change Date: _____

Irrigation: _____

Frequency: _____

WOUND CARE:

Location: _____ Size: _____

Type: _____ C&S Date: _____

Culture Results: _____

Frequency: _____

FEEDINGS:

Type: _____

Frequency: _____

Amount: _____

PHYSICAL THERAPY: ☐ ROM ☐ Ambulation ☐ Strengthening ☐ Gait ☐ Transfers ☐ Total Hip Protocol ☐ Total Knee Protocol

Other: _____

Frequency: _____ Duration: _____

RESPIRATORY THERAPY:

Type: _____

Frequency: _____

Suctioning: _____

OXYGEN THERAPY:

O2 / Liter: _____

Mask / Nasal Canula: _____

PRN / Continuous: _____

All durable medical equipment & supplies require written prescription

OTHER ORDERS (Diet, restrictions, activity, OT, ST, patient and family education, etc.):

PRACTITIONER'S NAME	NPI#	PRACTITIONER'S SIGNATURE	DATE

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HOSPITAL OR MEDICAL FACILITY	STATUS

DEPARTMENT / SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN

RELATIONSHIP TO SPONSOR