Direct admit to skilled nursing facility (SNF) request form

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Patient	
Name:	Date of birth:
Height:	Weight:
HIC #:	Policy ID #:

Skilled nursing facility	
SNF:	Contact:
Address:	
Phone:	Fax:

Orders		
Skilled need:		
Prior level of ability:		
Allergies:		
Diet:	Code status:	O2 needs:

Tuberculosis screening		
SNF can give PPD or CXR at time of admission: ☐ Yes ☐ No	Confirmed by:	
Free of TB:	CXR date:	PPD date:

Therapy evaluate and treat:	☐ Physical	☐ Occupational	☐ SLP
Patient/responsible party is aware of medical problem:		☐ Yes	☐ No
May have flu vaccine if not allergic to eggs:		☐ Yes	☐ No
May have Pneumovax:		☐ Yes	☐ No
May have annual PPD/CXR:		☐ Yes	☐ No
May crush medications and open capsules PRN:		☐ Yes	☐ No
May give medications with jelly or food:		☐ Yes	☐ No
May use generic medications unless otherwise stated:		☐ Yes	☐ No
May stop PRN medications not used in 7 days:		☐ Yes	☐ No

Additional miscellaneous orders or treatments

Patient's name _____ DOB _____/_____/_____

Narcotic prescriptions need to follow DEA and state law requirements.

Active medications			
Medication	**Purpose**	**Dosage/route**	**Frequency**

If not listing medication(s) above, check box. Then attach signed/dated medication list.

☐ Signed and dated medication list attached ☐ Please accept H&P as current

_____

Physician printed name

_____ _____

Physician signature Date

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