Teresian House Scheduled Short Term Care
Physician's Medical Report and Orders

Teresian House provides temporary short-term inpatient and medical care to the elderly being cared for at home while providing "Respite" for their caregivers.

Your patient named below has applied for a ____ day scheduled short term care stay at Teresian House from:
Dates: _________________ to _________________ Dates _______________ to _______________
Dates: _________________to __________________ Dates_______________ to _______________

Patient's Name: ________________________________ Social Security# _______________________
Address: ____
Birthdate: _________________ Sex _______

IMPORTANT INFORMATION: Doctor, to complete this form you must have examined your patient within the past **3** months. If you have NOT done so, a complete physical must be done in order to complete this form.

Date of most recent physical exam: _______________________________

ALLERGIES:____

DIAGNOSES	**MEDICATIONS:**	**DOSAGE**
I. PRIMARY		
II. SECONDARY		

NOTE: Applicants will be asked to bring in all bottles of medications prescribed to them. Medications must be in properly labeled vials and they must have sufficient medication for the respite stay. If changes are necessary a staff physician at Teresian House will order the appropriate medications/changes.
DIET: ____

ASSISTIVE DEVICES (If any) ____

CURRENT TREATMENTS (Include dressings; rehabilitative therapy such as PT, OT, ST, Please include where receiving, etc.)

____

____

____

BEHAVIORAL CONCERNS ____

MENTAL STATUS: ORIENTATION _____ TIME ______ PERSON ______ PLACE ______
Memory: ____

ADL'S: Eating: ______________________________________

Mobility: ____________________________________

Transfers: ___________________________________

Toileting: ___________________________________

Note: Teresian House will provide physical, occupational and speech therapy to participants of our short-term care program if the patient is currently receiving rehabilitative therapy while living at home. If your patient is currently involved in a program and you would like this to continue while at our facility, you must include a prescription requesting this. We will not provide therapy to anyone who is not receiving it at home.

WITHIN THE PAST 12 MONTHS, HAS YOUR PATIENT HAD A PPD?
YES __________ DATE ________________ RESULTS __________________________________

IF POSITIVE, CXR RESULTS ____

NO _________ UNKNOWN ___________________________________

PLEASE NOTE: A PPD OR CHEST X-RAY REPORT IS REQUIRED BEFORE ADMISSION CAN BE APPROVED. IF NEITHER HAS BEEN DONE, PLEASE INFORM YOUR PATIENT SO THAT ARRANGMENTS CAN BE MADE.

PREFERRED HOSPITAL FOR ADMISSION ____

PREFERRED PHYSICIAN FOR ADMISSION ____

PLEASE NOTE: A prescription authorizing admission into our short-term program is required. Please include a prescription written as follows: "**Scheduled short term care as needed to provide temporary inpatient and medical care".**

WHEN THIS FORM IS COMPLETED PLEASE RETURN IT ALONG WITH PRESCRIPTION(S) TO:

Tracy A. Sinnott
Director of Admissions
Teresian House
200 Washington Avenue Extension
Albany, New York 12203-5394

MD Signature ____
Print Name ____
Address ____
Phone ____
License Number ________________________ Date ____________________________________