Meadowlark Assisted Living
1009 3rd Ave. N
Great Falls, Mt 59401
406-452-6400

MontCare, Inc

Bluebird Assisted Living
1101 24th Ave. SW
Great Falls, Mt 59404
406-453-5800

MEDICAL HISTORY

Applicant Name:_____ Date:_____

Medical Release Authorization:_____
(Resident/legal representative signature)

Physician Name:_____Phone:_____

Physician Address:_____

Dear Dr._____,

The above named individual has hereby signed authorization for you to assist in the evaluation for placement in our assisted living residence. Please complete and return this form, releasing any pertinent documents that may be helpful in providing care at our residence.

Diagnosis:_____

_____

_____

Current medical problems:

_____

_____

Medical/Surgical history:

_____

_____

Dietary restrictions (therapeuticdiets not available):

_____

_____

Can applicant monitor his/her own dietary restrictions? Yes ___ No___

History of destructive, aggressive or violent behavior or mental illness:

_____

_____

Blood Press._____ Pulse _____ Resp. _____ Temp_____ Height _____ Weight _____

Date of Immunizations: Flu _____ Pneumovax _____ Tetanus_____

Date of last PPD _____ Results: _____

Date of last chest X-ray: _____ Results: _____

Does applicant presently suffer from any communicable disease? Yes ____ No ____

If yes, please describe:_____

Current Medications and Treatments:

Drug: Dose: Directions:

_____

_____

_____

_____

PRN Medications:

_____

_____

Which medications would you like to be notified of if refused?_____

_____

Allergies:

_____

_____

Does applicant have any of the following conditions? If so, please describe below:
Incontinence Yes ___ No ___
Ambulating Problems Yes ___No ___
Sensory Deficits Yes___ No ___
Colostomy Care Yes___ No ___
Foley Care Yes___ No ___
Recent Falls Yes___ No ___
Oxygen Yes___ No ___ Flow rate: _____
Assistive Devices:Yes___ No ___

Other Concerns:

_____

_____

____ I authorize the ALR staff to possess and supervise the administration of medications for this applicant according to the prescribed directions included here. These medications have been reviewed and approved.
____ This resident may self-administer all medications

To the best of your knowledge, could this individual function in assisted living without the benefit of skilled services on a regular basis? Yes____ No____

Dr._____ Signature_____ Date:_____

Please call if you have questions.
Sincerely, _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Montana Provider Orders For Life-Sustaining Treatment (POLST)

*THIS FORM MUST BE SIGNED BY A **PHYSICIAN, PA** or **APRN** IN SECTION E TO BE VALID*

If any section is NOT COMPLETE:

Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male ☐ Female ☐

Section A

Select only one box

Cardiopulmonary Resuscitation: If patient does not have a pulse and/or is not breathing:

☐ **Resuscitate (Full Code)**

☐ **Do Not Resuscitate (No Code)**
(Allow Natural Death)(Comfort One)
Patient does not want any heroic or Life-saving measures.

If patient is not in cardiopulmonary arrest, follow orders found in section **B** and **C**

Section B

Select only one box

Medical Interventions: If patient has a pulse and/or is breathing:

☐ **Comfort Measures:** Please treat patient with dignity and respect. Reasonable measures are to be made to offer food and fluids by mouth and attention must be paid to hygiene. Medication, positioning, wound care, and other measures shall be used to relieve pain and discomfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **EMS**: Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.

☐ **Limited Additional Interventions:** In addition to the care described above, cardiac monitoring and oral/IV medications may be provided. **EMS:** Transfer to hospital if indicated, do not perform intubation or advanced airway interventions. **Hospital:** Do not admit to Intensive Care.

☐ **Full Treatment:** In addition to the care described above, endotracheal intubation, advanced airway interventions, mechanical ventilation, defibrillation and cardioversion may be provided. **Hospital:** Admit to Intensive Care if indicated.

Other Instructions:

Section C

May select more than one

Artificial Fluids and Nutrition:
☐ Feeding tube ☐ No Feeding tube
☐ IV fluid ☐ No IV fluid
Other Instructions:

Antibiotics and Blood Products:
☐ Antibiotics ☐ No Antibiotics
☐ Blood Products ☐ No Blood Products
Other Instructions:

Section D

Advance Directives: The following documents also exist:
☐ Living Will ☐ Other _____

_____

Section E

Patient or **Surrogate Signature:** _____ Date:_____
(by signing the POLST, I agree that this POLST supersedes my living will, if the two conflict)

Print Patient or Surrogate *(person with authority under 50-9-106, MCA)*

Name:_____ Relationship:_____

Physician/APRN/PA *(in consultation with supervising physician)* **Signature:** _____ Date:_____

Print Physician/APRN/PA Name : _____ MT License Number: _____

Contact Phone Number: _____ **Discussed with:** ☐ Patient ☐ Spouse ☐ Other _____

The basis for these orders is: ☐ Patient's request ☐ Patient's known preference _____

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid