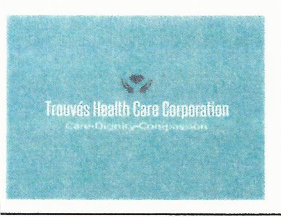

TITLE:	PROVISION FOR OUTSIDE HEALTH CARE PROVIDER	POLICY 3.06

Authority: WAC 388.78A.2340, Resident arranged services
RCW 18, Businesses and Professions
RCW 70.127, In-home services agencies
RCW 18.20.280, General responsibility for each resident
RCW 70.129.030, Notice of rights and services

PURPOSE:

This policy provides guidelines for those instances where residents wish to receive on-site care from an outside provider.

SCOPE:

This policy applies to residents and outside providers using Trouves Health Care facilities.

DEFINITIONS:

Provider:

A person licensed by the State of Washington to provide health care services. These services are provided within the scope of their profession as outlined in RCW 18.

POLICY:

A. Trouves health care supports residents right to choose healthcare providers. In this effort, residents may receive on-site care and services from:
   1. A practitioner, licensed under Title 18 RCW regulating health care professions; and
   2. A home health, hospice, or home care agency licensed under chapter 70.127 RCW.

B. The resident or resident's legal representative may independently arrange for other qualitied persons to provide on-site care and services to the resident.

C. Trouves does not supervise the activities, care or services, when these services have been independently arranged. The resident or legal representative is

responsible to notify the charge nurse and schedule space for the appointment a minimum of 72 hours in advance of service.

D. Trouves does require that the provider provide proof of a valid license to practice in the State of Washington and services provided must be in the scope of this license.

E. When the resident or the resident's representative, if any, independently arranges for outside services, the assisted living facility's duty of care, and any negligence that may be attributed thereto, shall be limited to: Policy statement "C"; observation of the resident for changes in overall functioning, consistent with RCW 18.20.280; notification to the person or persons identified in RCW 70.129.030 when there are observed changes in the resident's overall functioning or condition; and appropriately responding to obtain needed assistance when there are observable or reported changes in the resident's physical or mental functioning.

EXCEPTIONS:

No exceptions to this policy may be granted without the prior written approval of the Director.

SUPERCEDES:

None

ADMISSION INFORMATION

Dear Physician:

The individual named below is requesting assistance from our Assisted Living Department at Foundation House at Northgate. The following information is needed in order for us to fully assess the applicant's appropriateness for our community and to provide services

Thank you.

Name:	Birth Date:
Diagnoses: ______________________________	
Blood Pressure:	Weight:
Current Medications: (please verify dosage and time given on following page) Additional orders : ______________________________	
Allergies and Contraindication: ______________________________	
Diet: ( ) General ( ) Encourage a General Low Sodium Diet ( ) Encourage a General Diabetic Diet ( ) Mechanical soft ( ) Prescribed General Low Sodium Diet ( ) Prescribed General Diabetic Diet	
Mental Status/Mental Health Concerns	
Medical History & Physical (May attach current clinical records)	
Special Problems:	
Is applicant physically able to participate in outings?	☐ YES ☐ NO
In case of emergency, are you willing to be called as the personal physician?	☐ YES ☐ NO
PHYSICIAN SIGNATURE Name: ______________________ Address: ______________________ Phone # : ______________________	Date: ______________________ Signature: ______________________ City, State, ZIP: ______________________ FAX#: ______________________

ADMISSION PHYSIAN'S ORDERS

RESIDENT: ______________________________ **DOB:** ______________

1. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
2. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
3. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
4. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
5. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
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10. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
11. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
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16. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
17. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn
18. ______________________ DX: ______________ QTY: ________ Refills: 0 1 2 3 4 5 prn

Physician Signature: ______________________________ DATE: ____________

*** Substitution Permitted _____ Dispense as Written: _____ DEA#: ______________

PRE-ADMISSION ASSESSMENT

NAME: DOB DIAGNOSIS

MEDICAL HISTORY

MEDICATIONS

SPECIFIC BEHAVIOURS

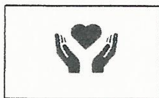
MENTAL ILLNESS DIAGNOSIS

LEVEL OF CARE NEEDS

ACTIVITIES & SERVICE PREFERENCES

DAILY ROUTINES

FOOD PREFERENCES/ALLERGIES



Trouves Health Care

Authorization for Release of Information

NAME:

BIRTHDATE:

THIS WILL AUTHORIZE:

To release all medical records, including information related to medications and treatments (unless specifically limited)

Please release this information to:

Trouves St. Ann's Inc.
6602 S Alaska ST
Tacoma, WA 98408

SIGNATURE

RESIDENT____

DATE____________________

WITNESS____

DATE____________________