Session One

CLINIC

PROGRESS NOTES

Clermont, Tess
02110895

Date: *Current* **Time:**

VS: T 98.7 P 70 BP 130/80 R 18

Student instructions: Geriatric Session Family Medicine Clerkship

Clinical Context: You are seeing an established patient named Mrs. Tess Clermont in your practice. Her regular primary care physician is retiring from the practice and the patient will now be in your care. She presents for a follow-up visit concerning memory loss and functional decline. The patient's son Les Clermont has accompanied her and is concerned about her condition.

- We will review the patient's chart and history as a group.
  PLEASE DO NOT WRITE IN THE CHART!
- When Prompted, swipe in and enter your assigned room. You will have 30 minutes with your patient.
- At 20 minutes into the encounter you will hear one bell to signify a 10 minute warning. Begin wrapping up at that time.
- At the end of the encounter you will hear two bells. End the encounter, step out of the room and swipe out.

During Encounter:

- Take a history.
- Identify the patient's primary diagnosis, explain the cause of her cognitive and functional impairments, and make treatment recommendations.
- Address questions posed by patient or her daughter.
- Apply content from the pre-session primer on dementia diagnosis and management.
- DO NOT perform a physical examination or administer the mini-mental status test; the pertinent test results are supplied in the patient's chart.
- Assume for this exercise that the patient has an unremarkable general medical examination including no focal neurological deficits.

Following Encounter:

- Take the written assessment and plan exercise from the chart table and begin. You will have 10 minutes to complete this exercise.
- You will submit your written assessment and plan to the faculty facilitator during the final debriefing session.
- When prompted, swipe back in and enter the encounter room. You will have a 10-minute verbal feedback session with the standardized patients.
- At the end of the feedback session you will hear two bells. Step out of the room and swipe out.
- Following your feedback session, meet in the conference room for a group debriefing session lead by the faculty instructor.

Session One

CLINIC

PROGRESS NOTES

Clermont, Tess
02110895

Date: *1 month prior* **Time:**

CC: Daughter called; concerned re: patient's "memory loss"

S: This 78 year old female with OA, HTN, and osteoporosis has been noted by her son(Les, per phone message) to be having increased memory difficulties. Patient denies memory impairment. Son is unsure of exact onset, but estimates about 2 years. No history of falls or head trauma. Patient reports feeling well and denies mood alteration, weakness, paresthesias, gait difficulties, urinary incontinence, heat or cold intolerance, or impaired activities of daily living.

Meds – ASA, HCTZ 25 daily, Oscal w/ Vit D tid, Fosamax 70 mg weekly

ROS- Usual mild chronic knee pain, otherwise non-contributory.

Exam- Wt. Stable . BP 130/80 P 80 R 18
Well appearing, cooperative, pleasant female. Alert oriented times three.
RRR, No murmur. Lung fields clear bilaterally.
General Exam is unremarkable.

Non-focal neurologic exam. Normal gait.
Short term memory: 5 minute recall 0/3.

Assessment / Plan:

78 year old female presenting with memory impairment of insidious onset with no apparent functional deficits, at least per her history. Differential diagnosis: mild cognitive impairment vs. early dementia.

Memory Impairment Work-up: Will need MOCA test.
Patient agrees to let her son attend next office assessment to provide more collateral history. Laboratory evaluation today to rule out reversible causes. Head CT.

HTN – Well controlled. Continue HCTZ.
RTC in 1 month

L. Jacobs, M.D. Date

Session One

The University Hospital 234 Goodman Ave, Cincinnati, OH 45267

Patient Name: Clermont, Tess
Med Rec # : 02110895
Patient type: Outpatient
78 F

RESULTS SUMMARY (Date: Three weeks prior)

	Normal Range	Units	Value
CBC			
WBC	3.5 – 11.0	10*3/uL	7.4
Hgb	13.6 – 18.0	g/dL	14.0
HCT	40.0 – 52.0	%	45.0
MCV	82.0 – 98.0	fL	86.1
RDW	11.5 – 14.5	%	13.2
Platelet Count	140 – 400	10*3/uL	316

	Normal Range	Units	Value
RENAL STUDIES			
Sodium	136 – 146	mEq/L	141
Potassium	3.5 – 5.0	mEq/L	4.1
Chloride	100 – 110	mEq/L	101
CO2	23 – 31	mEq/L	25
BUN	7 – 21	mEq/L	12
Creatinine	0.7 – 1.4	mEq/L	0.9
Glucose	70 – 105	mEq/L	84
Anion Gap	3 – 16	mEq/L	15

	Normal Range	Units	Value
Alkaline Phosphatase	44 – 160	U/L	150
AST	11 – 35	U/L	22
ALT	7 – 46	U/L	15
BILI, Total	0.2 –1.0	mg/dL	0.4
BILI, Direct	0.0 – 0.3	mg/dL	0.1
Protein, Total	6.2 – 7.9	g/dL	7.2
Albumin	3.4 – 4.8	g/dL	4.0
Calcium	8.4 – 10.2	mg/dL	9.2

Session One

The University Hospital 234 Goodman Ave, Cincinnati, OH 45267

Patient Name: Clermont, Tess
Med Rec # : 02110895
Patient type: Outpatient
78 F

RESULTS SUMMARY

	Normal Range	Units	Value
THYROID STUDIES			
TSH	0.35 – 5.50	MIU/ml	1.33

	Normal Range	Units	Value
VITAMIN STUDIES			
Vitamin B12	240 – 911	pg/ml	710
Folate	REF > 5.4	ng/ml	11.0

	Normal Range	Units	Value
RPR	non reactive	titer	non reactive

Session One

The University Hospital 234 Goodman Ave, Cincinnati, OH 45267

Patient Name: Clermont, Tess
Med Rec # : 02110895
Patient type: Outpatient
78 F

CT HEAD WO CONTRAST ACC # : 2362430

Exam Date: 2 weeks prior.

Verified

UNIVERSITY HOSPITAL
Reason: Memory impairment
Dictated by: Langston, Robert

Exams:
CT HEAD WO CONTRAST

Comparison: None

Brain Findings:

Mild cerebral atrophy noted, appropriate for patient's age. No evidence for acute infarction or intracranial hemorrhage. Orbits and sinuses appear unremarkable. Normal bone windows.

Impression:

1. Mild cerebral atrophy; otherwise normal non-contrast head CT.

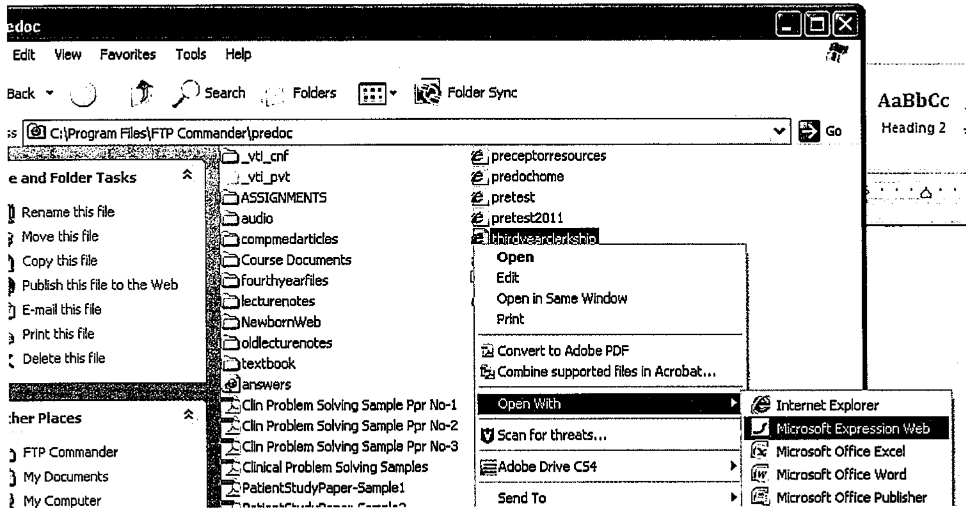
**** end of result ****

cc: Linda Jacobs, M.D.

Updating Third Year Clerkship page on www.familymedicine.uc.edu

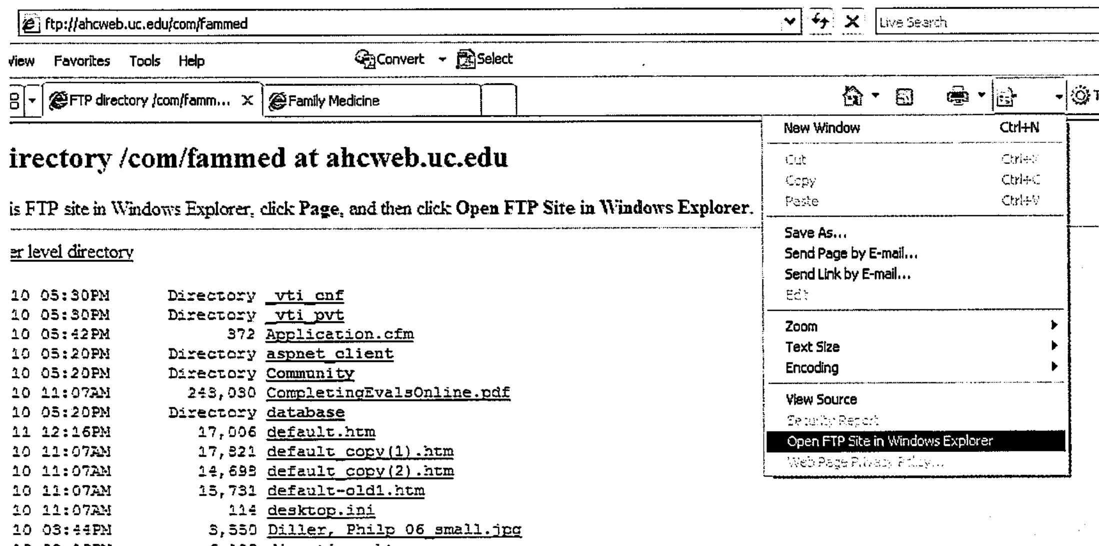
1. Open folder where web files are saved (on local computer)

open My Computer
select Local Disk C: > Program Files > FTP Commander > Predoc
right click on thirdyearclerkship.htm
select Open With – Microsoft Expressions Web



2. Open FTP site (where files for website are stored on the server)

open Internet Explorer
Under Favorites, select FTP directory-com-fammed at achweb.uc.edu
username = ucads/dooganla password = S@rge45233
Click Logon
In top right corner of browser window, select Page
From dropdown menu, select Open FTP site in Window



Re-enter username and password, click Logon

3. Edit page in Microsoft Expressions Web

In Microsoft Expressions Web application, thirdyearclerkship.htm page should be open (from actions in step 1), edit any text as needed

Save documents (the new PDFs) in web folders on computer in the C: > Program Files > FTP Commander > Predoc folders

I usually save the lecture schedules in the Course Documents folder and the due dates for assignments in the Assignments folder

To add hyperlinks from text to documents, in Expressions Web highlight text

Right click highlighted text

Select Add Hyperlink (or Modify Hyperlink)

In pop-up window, on left side, make sure Existing File of Web Page is selected

Navigate to folder where document for upload/hyperlink was saved, select document

Before clicking OK, select the Target Frame button (on right side of pop-up window)

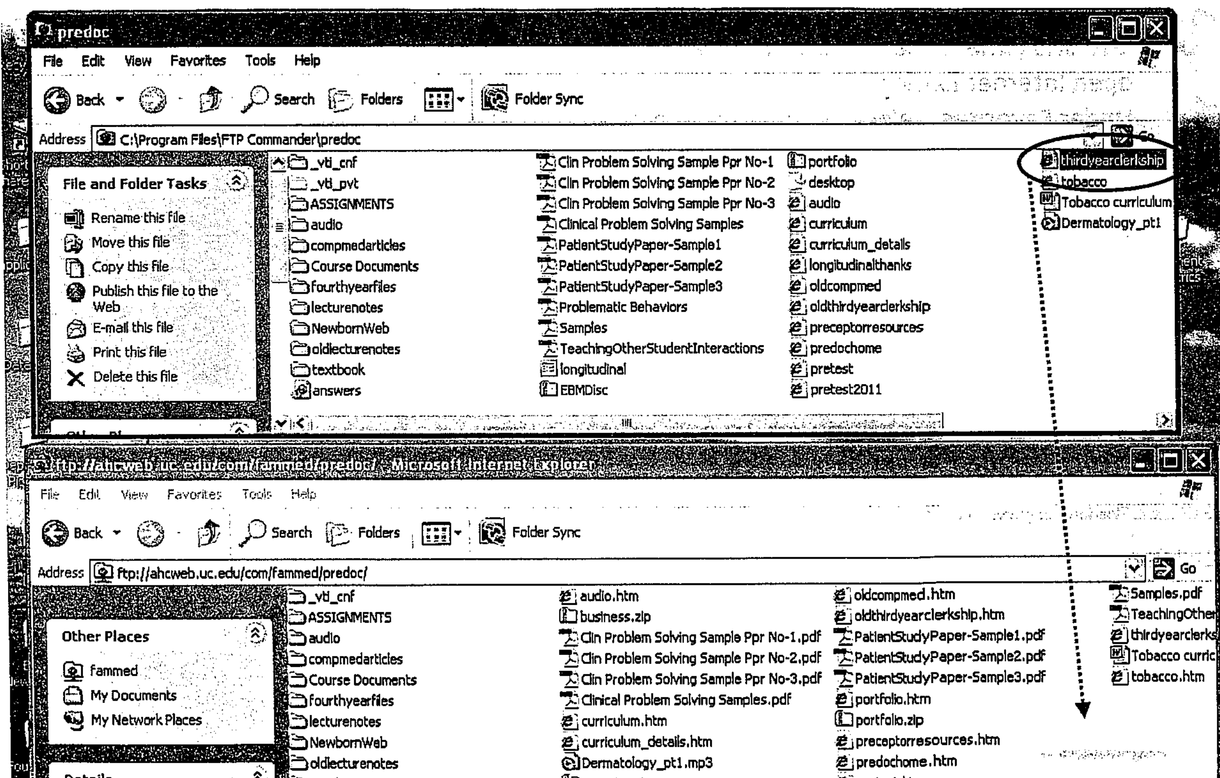
Select new window from common targets box

Click OK

When all text and hyperlinks have been added/modified, save thridyearclerkship.htm document

4. Transferring thirdyearclerkship.htm file from computer to web server

With both the FTP site folders (files housed on server - address will read ftp://ahcweb.uc.edu/com/fammed/predoc/) and FTP commander (files housed on computer – address will read C:\Program Files\FTP Commander\predoc) open, drag and drop the thirdyearclerkship.htm from FTP commander > predoc to ftp://achweb.uc.edu > Predoc



Click Yes to All when prompted

You'll also need to drag and drop the new PDF files for upload that were hyperlinked from FTP commander > predoc folders to ftp://achweb.uc.edu > Predoc folders

THE UNIVERSITY HOSPITAL

CLERMONT, Tess

#02110895

PROBLEM LIST

PROBLEM	Responsible Provider
1. osteoporosis	
2. OA	
3. essential HTN	
4. mild presbycusis	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

NKDA

Resolved Problems/Procedures	Date
1. Tonsillectomy	childhood
2. DEXA scan - T-score -2.5	3/2010
3. Head CT - mild atrophy	4/2010
4. Colonoscopy - nl	3/2010
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

MEDICATIONS

Prescriber	Drug; Dose; Freq/Date
Jacobs	EC ASA 81mg qd
	HCTZ 25mg qd
	Oscal c̄ Vit D BID
	Fosamax 70mg qwk

Health Maintenance

Patient Name: Tess Clermont **MRN:** 02110895

Flex sig/colon	3/2010 nl						
Fecal occult blood							
Digital rectal exam	nl 2010						
Fasting lipid profile	LDL 120 3/10						
Influenza vaccine	9/10						
Pneumovax	4/10						
Pelvic/pap smear	⊖ x 3 (2008)						
Mammogram	nl 2010						
Breast exam	nl 2008						

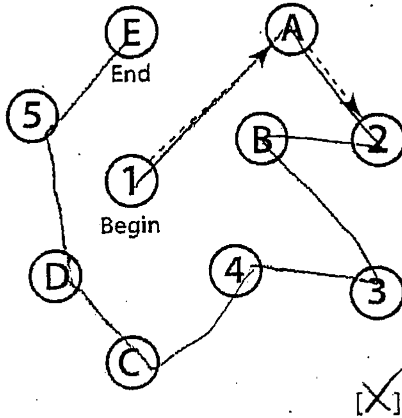
Social History: widow
husband ↓ lung CA 2009
lives alone

Family History: mo ↓ Alzheimers 80's
fa ↓ MVA 50's

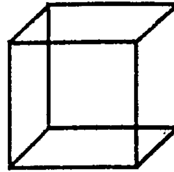
NAME: T. Clermont
Education: college   Date of birth: 78 y/o
Sex: DATE: 3/30/11, Wed.

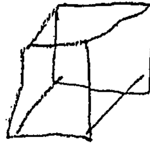
MONTREAL COGNITIVE ASSESSMENT (MOCA)

VISUOSPATIAL / EXECUTIVE

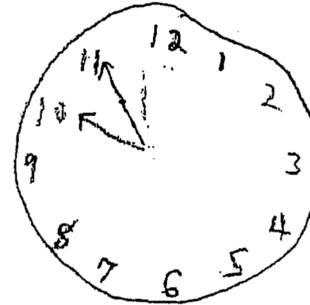


Copy cube



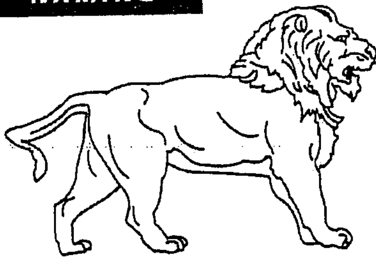


Draw CLOCK (Ten past eleven) (3 points)

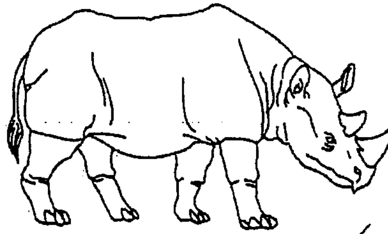


[X]   [✓]   [✓] Contour   [✓] Numbers   [X] Hands   3/5

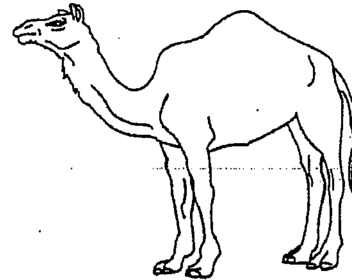
NAMING



[✓]



hippo [X]



[✓]   2/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial	✓	✓	✓	✓	✓
2nd trial	✓	✓		✓	

No points

ATTENTION

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [✓] 2 1 8 5 4
Subject has to repeat them in the backward order [X] 7 4 2   1/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[X] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B   0/1

Serial 7 subtraction starting at 100 [✓] 93 [✓] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**   2/3

LANGUAGE

Repeat: I only know that John is the one to help today. [✓]
The cat always hid under the couch when dogs were in the room. [X]   1/2

Fluency / Name maximum number of words in one minute that begin with the letter F [X] 7 (N ≥ 11 words)   0/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [✓] train – bicycle [✓] watch – ruler   2/2

DELAYED RECALL

Has to recall words	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
WITH NO CUE	[ ]	[✓]	[ ]	[ ]	[✓]	2/5
Optional: Category cue						
Multiple choice cue	✓			✓		

ORIENTATION

[✓] Date [✓] Month [✓] Year [✓] Day [✓] Place [✓] City   6/6

© Z.Nasreddine MD Version 7.1 www.mocatest.org Normal ≥26 / 30 TOTAL 19/30
Add 1 point if ≤ 12 yr edu

Administered by: ______

GERIATRIC DEPRESSION SCALE (Short Form)

Patient Jess Clermont Date 4/2/11

Choose the best answer for how you felt over the past week.

For each underscored answer, enter one point here.

1. Are you basically satisfied with your life? .... Yes / No ____
2. Have you dropped many of your activities and interests? .... Yes / No 1
3. Do you feel that your life is empty? .... Yes / No ____
4. Do you often get bored? .... Yes / No ____
5. Are you in good spirits most of the time? .... Yes / No ____
6. Are your afraid that something bad is going to happen to you? .... Yes / No ____
7. Do you feel happy most of the time? .... Yes / No ____
8. Do you often feel helpless? .... Yes / No ____
9. Do you prefer to stay at home, rather than going out and doing new things? ... Yes / No ____
10. Do you feel you have more problems with memory than most? .... Yes / No 1
11. Do you think it is wonderful to be alive now? .... Yes / No ____
12. Do you feel pretty worthless the way you are now? .... Yes / No ____
13. Do you feel full of energy? .... Yes / No ____
14. Do you feel that your situation is hopeless? .... Yes / No ____
15. Do you think that most people are better off than you are? .... Yes / No ____

Cut-off: Normal (0-5). Above 5 suggests depression.

2 / 15
Total Score

SOURCE: Courtesy of Jerome A. Yesavage, MD. Reprinted with permission.

For additional information on administration and scoring refer to the following references:

1. Sheikh JL, Yesavage JA. Geriatric Depression Scale: recent evidence and development of a shorter version. Clin Gerontol. 1986:5:165-172.
2. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression rating scale: a preliminary report. J Psych Res, 1983:17:27.

*****FULL (30 Item) Geriatric Depression Scale is available for use*****

Mental Health Questions:

How much alcohol do you consume daily? sometimes a glass of wine a week

What is the quality of your sleep? OK

How is your appetite? very good

Have you been treated with medication or therapy for mental health problems, depression, and/or anxiety? no

____
Signature and Credential of Interviewer

PHYSICAL ACTIVITIES OF DAILY LIVING

Patient: TESS CLERMONT   Date: 4/2/11

Informant: LES CLERMONT   Relationship to patient: SON

How is the patient currently performing?

Code: I = Independent
A = Assisted
D = Dependent
Circle appropriate letter below.

Obtained from: Patient / Informant(s)

	Patient	Informant(s)	
Bathing	(I)	(I)	Able to bathe completely or needs help with only a single body part.
	A	A	Needs help with more than one body part, getting in/out of tub or special tub attachments.
	D	D	Completely unable to bathe self.
Dressing/ Undressing	(I)	(I)	Able to pick out clothes, dress self, manage fasteners/ braces (tying shoes excluded).
	A	A	Needs assistance as remains partially undressed.
	D	D	Completely unable to dress/undress self.
Personal Grooming	(I)	(I)	Able to comb hair, shave without help.
	A	A	Needs help to comb hair, shave.
	D	D	Completely unable to care for appearance.
Toileting	(I)	(I)	Able to get to, on and off toilet, arrange clothes, clean organs of excretion. (Uses bedpan only at night.)
	A	A	Needs help getting to and using toilet; uses bedpan/ commode regularly.
	D	D	Completely unable to use toilet.
Continence	(I)	(I)	Urination/defecation self-controlled.
	A	A	Partial or total urine/stool incontinence or control by enemas, catheters, regulated use of urinals/bedpans.
	D	D	Uses catheter or colostomy.
Transferring	(I)	(I)	Able to get in/out of bed/chair without human assistance/ mechanical aids.
	A	A	Needs human assistance/mechanical aids.
	D	D	Completely unable to transfer; needs lifting.
Walking	(I)	(I)	Able to walk without a cane.
	A	A	Needs human assistance, walker, or crutches.
	D	D	Completely unable to walk; needs lifting.
Eating	(I)	(I)	Able to completely feed self.
	A	A	Needs help with cutting, buttering bread, etc.
	D	D	Completely unable to feed self or needs parental feeding.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Patient: Tess Clermont   Date: 4/2/11
Informant: Les Clermont   Relationship to patient: son

How is the patient currently performing?

Code: I = Independent; A = Assisted; D = Dependent. *Circle appropriate letter below.*

Obtained from: Patient, Informant(s)

Activity	Patient	Informant(s)	Description
Using Telephone	**I**	I	Able to look up numbers, dial, receive, and make calls without help.
	A	**A**	Able to answer telephone or dial operator in an emergency, but needs a special telephone or help in getting a number or dialing.
	D	D	Unable to use telephone.
Traveling	**I**	I	Able to drive own car or travel alone on busses, taxis
	A	**A**	Able to travel, but needs someone to travel with.
	D	D	Unable to travel.
Shopping	**I**	**I**	Able to take care of all food/clothes shopping with transportation provided.
	A	A	Able to shop, but needs someone to shop with.
	D	D	Unable to shop.
Preparing Meals	**I**	I	Able to plan and cook full meals.
	A	**A**	Able to prepare light foods, but unable to cook full meals alone.
	D	D	Unable to prepare meals.
Housework	**I**	**I**	Able to do heavy housework, i.e., scrub floors.
	A	A	Able to do light housework, but needs help with heavy tasks.
	D	D	Unable to do any housework.
Taking Medicine	**I**	I	Able to prepare/take medicine(s) in the right dose at the right time.
	A	**A**	Able to takes medicine(s), but needs reminding or someone to prepare it.
	D	D	Unable to take medicine(s).
Managing Money	**I**	I	Able to manage buying needs, write checks, pay bills.
	A	**A**	Able to manage daily buying needs, but needs help managing checkbook, paying bills.
	D	D	Unable to handle money.

c Tess Clermont

Social Status Review by Patient

Date of Birth: ______________________ Age: 78

(All information should be validated with informant.)

List informants (include age, relationship to patient, location):

Les Clermont - son - pt currently living c son

Your main concerns about how you are feeling would be... "sometimes forgetful"

- memory loss per son

Educational: You went how far in school? college graduate BA - Ed
(Include years completed)

Employment: Your longest type of employment was..... (Give place and years):

School teacher x 40 yrs retired at age 70

You retired because of.. wanted to spend time c family

Life changes/Losses: Over the past 5 years, I wonder if you have had significant changes which still impact on you? i.e., relocation, retirement, new social activities, death of relative/friend, divorce, illness of a family member....

my husband died last year

On a routine day at home, I wonder how stressed you might feel... pretty good

Social Resources: Your household members include: myself · Mickey

Mickey - dog Pets: Yes ✓ No ____

Any relationships which are troubling you now? no

If you need help, you generally call on... my daughter, son or friend Lau

I wonder if you became disabled due to a stroke/accident and could not care for yourself, what your care plans would be? like to have in home care or a helper

____
Signature & Credential of Interviewer

1. PRESENTING PROBLEM as described by informant changes in memory

2. You first noticed a change (Date): 1-2 yrs ago

3. Specific examples of first behaviors noticed: Forgetting conversations

Special examples of current behaviors: losing small items - using lots of post it notes for phone #'s, forgot to pay bills, left pot on stove

How does this interfere with patient's routine activities?

Having trouble driving not keeping fridge in order

4. Please describe the patient before these changes: organized, outgoing, smart

5. If you had to give a diagnosis it would be: Alzheimers?

6. Does anyone have power of attorney (or DPOA)? yes

INFORMANT: For DX of dementia:

Is respite needed for caregiver? NO

Does caregiver attend support group? No

Has caregiver reviewed any related literature? NO

Please rate your current (today) level of coping with the memory change in your family member.

Name of informant: ______

1	(3)	5	10
No problem		Some stress	Very

More than one informant: ______

Would you be interested in Alzheimer's Disease Registry? Yes ✓ No ______

______

Signature & Credential of Interviewer

Safety Status Review

Abuse potential/history documented? (If so, describe.) NO

Wandering potential/history documented? (If so, describe.) NO

Kitchen safety concerns? (If so, describe.) yes- pt burned pot on stove

Driving safety concerns? (If so, describe.) yes - pt got lost

Other safety concerns? no guns, no h/o falls

(Note to clinician): Are there indications that the patient is being abused, neglected or exploited?: No

Financial Status Review:

Please check annual income range.

___ Less than $3,000	___ $3,000- $8,000	___ $8,000-$13,000
___ $13,001 - $18,000	___ $18,001-$21,000	✓ $21,001-$26,000
		___ $26,000

Do you feel you will have enough income for your future needs?

✓ Yes ___ No Explain: owns home, has state teachers retirement fund

Contributing Family History: ✓ Yes ___ No

Explain: mo ↓ alzheimers 80's.

[signature]

Signature & Credential of Interviewer

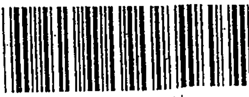
COMMUNITY SERVICES

Patient Tess Clermont Date 4/3/10

Informant Les Clermont Relationship to patient son

Check appropriate answer for each listed service.

SERVICE	Never used	Used in past	Uses currently	Needed, but not affordable
Visiting Nurse				
Housekeeping Services		✓		
Adult Day Care				
Public Transportation		✓		
Meal Delivery/Preparation				
Mental Health Counseling				
Physical Therapy Services				
Occupational Therapy Services				
Clergy Services		✓		
Respite Care				
Rest Home				
Nursing Home				
Rehabilitation Services				
Other: ____________				



NURSAH

THE UNIVERSITY HOSPITAL
PATIENT HISTORY/ INITIAL ASSESSMENT FORM

PT TESS CLERMONT
INFORMANT LES CLERMONT (SON)

Date: ______ Time: ______ Unit: ______
Reason for admission: ______
Consent for treatment ☑ Y ☐ N ADM
Patient identified by name and birth date ☑ Y ☐ N
White armband on ☑ Y ☐ N (If N, place on patient)
Person/source providing information Pt
Unable to obtain history due to: ______

1st Emergency contact/relation	Phone number	Medical information may be given to:
Les Clermont (S)	513 233-9020	☑ 1st ☑ 2nd Emergency contact/relation
2nd Emergency contact/relation	Phone number	Other:
Linda Sturns (d)	513 233-2150	Other:

Admitted From: (Home) ☐ Nursing home (Name: ______) ☐ Hospice ☐ Emergency room
Physician's office ☐ Group home ☐ Other:

Primary Language: ☑ English
☐ Other: ______ ☐ Deaf/HOH
Communication barriers: ☐ Y NS ☐ N

Allergies: (Medication, adhesive tape, or environmental)
☑ No known allergies ☐ Allergic to latex CS/NS ☐ Allergic to food NS

Allergic to NSG	Reaction	Allergic to NSG	Reaction

Red allergy armband placed on patient ☐ Y

Advance Directives: 1. Do you have:			Copy brought with patient		If not brought in with the patient provide contact information below
Living Will	☑ Y	☐ N	☑ Y	☐ N	Name: ______ Phone: ______
Durable Power of Attorney (POA) for Healthcare	☑ Y	☐ N	☑ Y	☐ N	Name: ______ Phone: ______ This person is the POA ☐
DNR	☑ Y MD	☐ N			

2. Family advised to bring advance directive to hospital ☑ Y ☐ N
3. Would you like information about advanced directives ☐ Y SW ☑ N

Clinical Research Trials:
1. Will you have anything done for a clinical research study while you are here? ☐ Y RC ☑ N
2. If Y, what kind of study is this?

Tobacco Use: ☑ Never ☐ Former; date last used: ______ ☐ Current: ______ packs or amount/day/ times ____ years
1. If patient has smoked cigarettes anytime during the year prior to hospital arrival, nurse advised patient that quitting improves current and future health ☐ Y RT
2. Patient informed that University Hospital is a tobacco-free campus ☑ Y
3. **Smoking cessation education material given to patient** ☐ Y ☐ Refused

Alcohol Use/Day: ☐ Denies use
☐ Y Last use: ______
1. If Y, amount: 1-2 glasses/mth
2. If Y, at risk for withdrawal? ☐ Y ☑ N

Recreational Drug Use: ☑ Denies use
☐ Y

Drug:	Last use:	Drug:	Last use:
Drug:	Last use:	Drug:	Last use:
Drug:	Last use:	Drug:	Last use:
Drug:	Last use:	Drug:	Last use:

Immunization/Vaccination History:
1. None / need immunization protocol ☐ NSG
2. Pneumonia (pneumococcal) Month/year 4/2010
3. Flu (influenza) Month/year 9/10 (Sept-Mar)

Preventative Screening:
1. Have you had a prostate screen? ☐ Y ☐ N NSG ☐ N/A
2. Have you had a mammogram? ☑ Y ☐ N NSG ☐ N/A
3. PAP within the last year? ☐ Y ☑ N NSG ☐ N/A

PATIENT BELONGINGS

☐ See patient belongings list
☑ **No belongings**

Item	Y	N	Describe		Sent home
Clothing	☐ Y	☐ N	Describe:		☐ Sent home
Dentures	☐ Y	☐ N	☐ Upper ☐ Lower		☐ Sent home
Hearing aids	☐ Y	☐ N	☐ Right ☐ Left		☐ Sent home
Glasses	☐ Y	☐ N	Describe:		☐ Sent home
Contacts	☐ Y	☐ N	Describe:		☐ Sent home
Money	☐ Y	☐ N	Amount:	☐ In safe	☐ Sent home
Jewelry ☐ Describe:				☐ In safe	☐ Sent home
Other ☐ Describe:					

Personal belongings: Items kept here ☐ Y ☐ N; items sent home with whom:

Nurse Name (Print): Susan Burke Nurse Signature: Susan Burke Date: ______ Time: ______

Significant Past Medical History: Have you had or has anyone ever told you that you had any of the following conditions?
☐ No problems

☐ Seizures: Frequency
☐ Blood disorders (Anemia/ Sickle cell)
☐ Pneumonia
☐ Hepatitis A / B / C , Cirrhosis
☐ Kidney problems
☑ High blood pressure
☐ Heart disease/ MI/ Heart failure
☑ Arthritis
☐ Cancer, type
☐ Diabetes
☐ Stroke
☐ Hospitalization in the past year
☐ Surgeries
☑ Other OSTEOPOROSIS

Education/Knowledge:
1. Understanding of current health problems: ☑ Knowledgeable ☐ Information needed
2. Learning preference: ☑ Listening ☐ Reading ☐ Visual ☐ Practicing Other
3. Able to read: ☑ Y ☐ N
4. Able to write ☑ Y ☐ N

PAIN ASSESSMENT SCREEN

1. Patient instructed on use of pain scale ☑ Y
2. Are you in pain now? ☐ Y MD ☑ N
3. Are you currently taking meds or using a pain control strategy? ☐ Y ☑ N

***If No on 2&3 STOP**

4. If Y, how severe is your pain? ____ (0-10)
5. Where is your pain located?
6. Is the pain ☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Radiating ☐ Other
7. When did your pain start?
8. How long does it last?
9. Does it affect your normal activities/quality of life? ☐ Y ☐ N ☐ N/A How?
10. What is your pain goal? ____ (0-10)

ABUSE/NEGLECT SCREEN

1. Exhibits any physical/emotional signs of physical/emotional/financial abuse or neglect? ☐ Y SW ☑ N
2. Do you feel safe in your current living situation? ☑ Y ☐ N SW

If N, explain:
Comments:

FUNCTIONAL SCREEN/FALL RISK ASSESSMENT

Are you currently having:

1. A decreased ability to walk, get in/out of a chair, or loss of balance? ☐ Y ☑ N
   Consider PT ☐ Y MD
2. A decreased ability to perform ADL's? ☐ Y ☑ N
   Consider OT ☐ Y MD
3. Difficulty swallowing/choking? ☐ Y ☑ N
   Consider SP for swallow ☐ Y MD
4. Difficulty speaking? ☐ Y ☐ N
   Consider SP ☐ Y MD
5. A need for assistance with meals? ☐ Y NSG ☑ N

NUTRITIONAL SCREEN

1. 10lbs of unintentional weight loss in past 2 months ☐ Y NS ☑ N
2. Patient on tube feeding/TPN at time of admission ☐ Y NS ☑ N
3. Decreased appetite/ oral intake greater than 1 week ☐ Y NS ☑ N
4. Nausea/vomiting/diarrhea greater than 3 days ☐ Y NS ☑ N
5. Does the patient experience problems with chewing ☐ Y NS ☑ N
6. Diet education requested by patient/family ☐ Y NS ☑ N
7. Pregnant or lactating female ☐ Y NS/RPH ☑ N

PATIENT SAFETY RISK SCREEN

☑ No risk at present time
☐ Potential risk NSG

☐ **Actual risk** NSG – **MAY NOT LEAVE THE UNIT** (Category I/Critical Missing)
☐ Threat to themselves/others
☐ Non-emancipated minor
☐ Probate or state mental hold
☐ Incarcerated patient
☐ Cognitive impairment that creates risk
☐ Other:

DISCHARGE SCREEN

1. Do you live: ☑ Alone ☐ With family ☐ Care giver other than self:
2. Do you plan on returning home: ☑ Y ☐ N
3. How will you return there?
4. Are you currently using: ☑ None ☐ Home health services CM ☐ Dialysis services SW ☐ Medical equipment CM ☐ ECF/Rehab SW ☐ Other
5. Do you have concerns related to your hospital stay or return home: ☑ None ☐ Medication costs ☐ Financial aid ☐ Children/dependents ☐ Need clothing SW ☐ Transportation to home SW
6. Anticipated disposition: ☑ Home self care/family assist
   ☐ Home with home health CM
   ☐ Facility placement SW
   ☐ End of life care SW/CH
   ☐ Other
   ☐ Unknown
7. Do you need Diabetic education? ☐ Y DOM/NS ☑ N

Nurse Name (Print): Susan Burpee Nurse Signature: Susan Burpee Date: ______ Time: ______

Psychosocial/Spiritual/Cultural

1. Is the admission due to self-harm? ☐ Y MD ☑ N
2. Has the patient had thoughts of killing or harming himself/herself? ☐ Y MD ☑ N
3. Needs suicide precautions ☐ Y NSG ☑ N

☑ Characteristics of appearance, behavior, mood and verbalizations are appropriate | ☐ Withdrawn ☐ Anxious ☐ Uncooperative ☐ Angry ☐ Tearful ☐ Impulsive ☐ Flat affect ☐ Inappropriate ☐ Combative MD ☐ Other

1. How do you deal with stress? Talk about
2. Who provides you with emotional support? my son & daughter

1. Is there anything we can do to help you meet your spiritual/religious/cultural needs? ☐ Y ☑ N

- ☐ Prayer/meditation CH
- ☐ Emotional or family issues CH/SW
- ☐ Dealing with spiritual issues or questioning life purposes CH
- ☐ Dealing with grief or physical/emotional loss CH/SW
- ☐ Transfusion restrictions MD
- ☐ Dietary practices NS
- ☐ Other:

Comments:

Safety

FALL ASSESMENT AND PREVENTION

Universal Fall Precautions	Level 2	Level 3
☑ Oriented ☐ Non-agitated ☐ Continent of bowel/bladder ☐ No fall history ☐ No sensory impairment or mobility impairment without accommodation	☐ Previous history of falls/fall during hospital stay ☐ Gait instability ☐ Lower extremity weakness ☐ Urinary incontinence/frequency/or assistance needed with toileting ☐ Sensory impairment ☐ Drugs such as sedatives, hypnotics ☐ Impaired judgment	☐ Extremely confused ☐ Extremely agitated ☐ Presents risk to self or others

Patient is a fall risk: ☐ Y ☑ N If Y, Patient is instructed not to get out of bed without assistance and fall risk precautions initiated IF FALL RISK PLACE SIGN ON DOOR AND APPLY YELLOW ARMBAND

Comments:

ORIENTATION TO ENVIRONMENT ☐ Unable to orient to environment

☐ Admission packet given to patient and contents reviewed	☐ Patient rights & responsibilities	☐ Call light, TV, phone, bed controls	☐ Unit specific information
	☐ Visiting policy	☐ Toileting	☐ Patient safety goals reviewed

If ICU/Step Down/SDS admission STOP HERE. See ICU/Step Down/SDS flow sheet for physical assessment data.

INITIAL PATIENT ASSESMENT

Vital signs: T P R BP (R/L): (Sitting/Lying/Standing) SPO2 ___ %

(Actual/Stated) Height: (Actual/Stated) Weight:

Skin Integrity

☑ Good turgor ☑ Dry ☐ Intact ☑ Warm ☐ Coccyx WNL ☐ Heels WNL

☐ Ecchymosis ☐ Jaundice ☐ Petechiae ☐ Rash ☐ Itching ☐ Poor turgor ☐ Cold ☐ Pale ☐ Ashen ☐ Hot ☐ Flushed ☐ Diaphoretic ☐ Incision ☐ Lesion ☐ Dressing ☐ Drainage ☐ Pressure ulcer WN/SB/NS ☐ Pain ☐ Wound (Describe)

Comments:

The skin evaluation is based on the status at the time of admission

Skin Risk

Risk Assessment	1	2	3	4	Score
Sensory perception	Completely limited	Very limited	Slightly limited	(No impairment)	
Moisture	Constantly moist	Very moist	Occasionally moist	(Rarely moist)	
Activity	Bedfast	Chairfast	Walks occasionally	(Walks frequently)	
Mobility	Completely immobile	Very limited	Slightly limited	(No limitations)	
Nutrition	Very poor	Probably inadequate	Adequate	(Excellent)	
Friction and shear	Problem	Potential problem	(No apparent problem)		20

TOTAL

Patients with score 16 or less are considered to be at risk of developing pressure ulcers ☐ Y WN/SB

Nurse Name (Print) Susan Burpee Nurse Signature Susan Burpee Date: ________ Time: ________

Cognitive/Neurological

- [x] Oriented
- [x] Person
- [ ] Place
- [ ] Time
- [x] Situation
- [x] PERRLA
- [x] Alert/awake
- [x] Speech clear
- [x] Steady gait
- [x] Normal sensation
- [x] Grasp equal

Pupil size : 4 mm

Sedated · Lethargic · Disoriented · Confused · Hallucinations · Impaired judgment · Recent memory changes · Depression · Verbally inappropriate · Slurred speech · Nonverbal · Aphasia · Numbness/tingling · Sensory loss · Unsteady gait · Grasp unequal · O2 · L greater than R · R greater than L · Weakness · R · L · Pupils unequal/nonreactive R ___ mm · R · L · L ___ mm · New neurological changes · Y · N · Unknown

Glasgow Coma Scale

		1	2	3	4	5	6	Score	TOTAL
Eye opening:	Eyes closed by swelling	None	To pain	To speech	Spontaneous	N/A	N/A		
Best verbal response:	Intubated/ trached	None	Incomprehensible	Inappropriate	Confused	Oriented	N/A		
Best motor response:	N/A	None	Extension to pain	Flexion to pain	Withdraws	Localized pain	Obeys command	15	

Comments:

Cardiovascular

- [x] Apical pulse regular
- [x] Peripheral pulses intact
- [x] Brisk capillary refill
- [x] S_1S_2

SOB with exertion · SOB with ADL's · SOB at rest · Chest discomfort · Numbness/tingling · Dysrhythmia · Irregular · Tachycardia · Bradycardia · Diaphoresis · Abnormal heart sounds · Edema · JVD · Sudden weight gain · Diminished pulses · Cap refill greater than 3 sec · + Homan's sign · R · L · Pacemaker · Implanted defibrillator · Vascular access device · IV/CVAD site

Comments:

Respiratory

- [x] Chest symmetrical
- [x] Non-labored breathing
- [x] Clear sounds
- [x] Regular rate
- [x] Normal airway

Needs isolation cart · Droplet CS · Airborne CS · Chest asymmetrical · Barrel chest · Chest tube · R · L · Crackles · Rhonchi · Wheezing · Cough/secretions · Dyspnea · Sleep apnea · Cyanotic · Oxygen ___ L/min · Pulse oximetry ___% RT · Nebulizer/MDI RT · CPAP/BiPAP RT · Trach size RT

Comments:

Gastrointestinal

- [x] Abdomen soft
- [x] Non-tender
- [x] BS present
- [x] Continent of stool

Last meal ______

Diet type ______

Last BM ______

Abdomen firm · Distended · Tender · BS absent · Hyperactive · Hypoactive · Heartburn · Nausea · Vomiting · Hematemesis · Constipation · Diarrhea · Incontinent · Melena · Hemorrhoids · Tubes/drains · Ostomy · Need ostomy care WN · Need ostomy education WN

Comments: · Bedside commode needed CS

Genitourinary

- [x] Continent
- [x] Urine clear

Date last menses N/A

Incontinent · Dysuria/nocturia · Anuria · Hematuria · Oliguria · Hesitancy/urgency · Frequency · Discharge · Urine cloudy · Urine foul odor · Vaginal bleeding · Lactating LS · Requires ISC q ___ · Catheter · Requires ISC q ___ · Catheter · Ileal conduit · Need ileal conduit care WN · Need ileal conduit education WN

Comments:

- [x] No referrals at this time

Referrals To:

- [ ] ADM · CH · CM · CS · DCM · IS · LS · [ ] MD · [ ] NSG · NS · [ ] RC · [ ] RPH · RT · [ ] SB · [ ] SW · [ ] WN

Referrals Entered By: Date: Time:

ADM = Admitting	LS = Lactation Specialist	RT = Respiratory Therapy
CH = Chaplain	MD = Physician	SB = Specialty Bed
CM = Case Manager	NSG = Registered Nurse	SW = Social Work
CS = Central Supply	NS = Nutrition Services	WN = Wound/Ostomy Care Nurse
DCM = Diabetic Case Manager	RC = Research Compliance	
IS = Interpreter Services	RPH = Pharmacist	

Nurse Name (Print): [illegible signature] Nurse Signature: [signature] Date: ______ Time: ______

State of Ohio
Health Care Power of Attorney
of

Tess Clermont

(Print Full Name)

____

(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Agent or **attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube "feedings."

Cardiopulmonary resuscitation or **CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Principal means the person signing this document.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: Les Clermont

Agent's Current Address: 510 Appletree Lane CINTI, OH 45230

Agent's Current Telephone Number: 513 233 -9020

Naming of Alternate Agents. [Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:	**Second Alternate Agent:**
Name: RON CLERMONT	Name: TED CLERMONT
Address: 280 Sycamore DR	Address: 300 Meadowview
CINTI, OH 45230	CINTI, OH
Telephone: 513 233-2150	Telephone: 513 221-9527

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Guidance to Agent. My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Authority of Agent. My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do not want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.

2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.

4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ, and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

    (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and

    (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and

    (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. **By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:**

1. I am in a permanently unconscious state; and

2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically

supplied nutrition and hydration will not provide comfort to me or relieve my pain; and

3. I have placed my initials on this line: JG

Limitations of Agent's Authority. I understand that under Ohio law, there are five limitations to the authority of my agent:

1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and

2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and

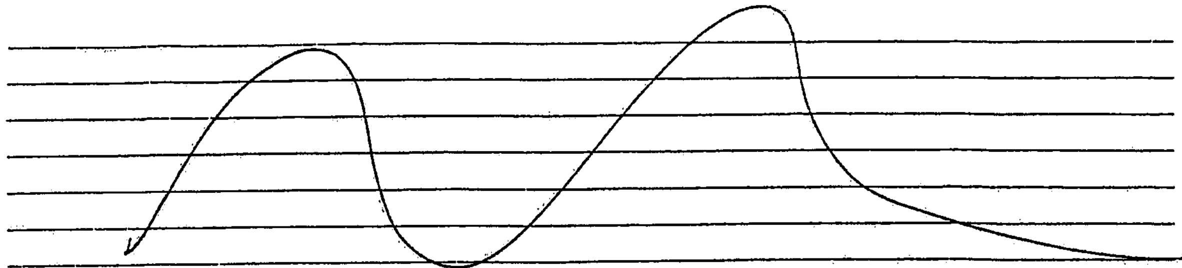
3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and

4. My agent cannot order the withdrawal of artificially or technologically supplied nutrition or hydration unless I am terminally ill or permanently unconscious and two physicians agree that nutrition or hydration will no longer provide comfort or relieve pain and, in the event that I am permanently unconscious, I have given a specific direction to withdraw nutrition or hydration elsewhere in this document; and

5. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations. I may give additional instructions or impose additional limitations on the authority of my agent. *[Note: On the lines below you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Health Care Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write "None" below or cross out the unused lines.]*

None



No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Guardian. I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Living Will. I have completed a Living Will: ✓ Yes ______________ No

SIGNATURE

[See next page for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on Jan, 2004, at Cincinnati, Ohio.

Tess Clermont
PRINCIPAL

[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Health Care Power of Attorney with your County Recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT
[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]

*[The following persons **cannot** serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*

Witnesses. I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

Bob Halbright residing at 180 S. State
Signature
Bob Halbright CINTI, OH
Print Name

Dated: 1/7/04, 2004

Edith Feldcamp residing at 258 Hickory Rd
Signature

Edith Feldcamp CINT, OH
Print Name

Dated: Jan 7th, 2004

OR

Notary Acknowledgment.
State of Ohio
County of _________________ ss.

On __________________________, 2004, before me, the undersigned Notary Public, personally appeared ______________________________ known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that he/she executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

____
Notary Public

My Commission Expires:_________

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

> (1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:
>
> > (a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if lifesustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.
> >
> > (b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable

degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below).

(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

> **(a) You are in a terminal condition or in a permanently unconscious state.**
>
> **(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**
>
> **(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**

(i) **Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**

(ii) **Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**

(d) **Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.**

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an

expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

Tess Clermont
LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☑ Female eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☑ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

Tess Clermont (signature) ☐ Check if verbal consent (Leave signature line blank) 8/1/09 10:00 am
SIGNATURE DATE/TIME

Tess Clermont
PRINT NAME OF DECISION-MAKER

Susan Burke / Nancy Mulvey
PRINT FIRST WITNESS NAME / PRINT SECOND WITNESS NAME

Who made the decision? ☑ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

C Jacobs (signature) / Charles Jacobs / 8/1/09 10 pm
PHYSICIAN SIGNATURE / PRINT PHYSICIAN NAME / DATE/TIME

OH 3807 8824 / (513) 489-5441
PHYSICIAN LICENSE NUMBER / PHYSICIAN PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☑ Health Care Proxy ☐ Living Will ☑ Organ Donation ☐ Documentation of Oral Advance Directive

 HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

T Clermont
LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION E Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

- ☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- ☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- ☑ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

- ☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should ***not*** be checked if full CPR is checked in Section A.)
- ☑ **A trial period** *Check one or both:*
  - ☑ **Intubation and mechanical ventilation**
  - ☑ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**
- ☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

- ☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- ☑ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. *Check one each for feeding tube and IV fluids:*

- ☑ **No feeding tube**
- ☐ **A trial period of feeding tube**
- ☐ **Long-term feeding tube, if needed**

- ☑ **No IV fluids**
- ☐ **A trial period of IV fluids**

Antibiotics *Check one:*

- ☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- ☐ **Determine use or limitation of antibiotics when infection occurs.**
- ☑ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, etc.).

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☑ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

Physician Signature for Section E

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

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T Clermont

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION F Review and Renewal of MOLST Orders on This MOLST Form

The physician must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
8/14/09	[signature]	Office	☑ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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