On-Belay House
Anthony Louis Center

Anthony Louis Center
1000 Paul Parkway
Blaine, MN 55434
763-757-2906

Anthony Louis Center
7700 Hudson Road, #600
Woodbury, MN 55125
651-731-0031

Anthony Louis Center
1517 E Highway 13
Burnsville, MN 55337
952-890-8879

ON Belay Plymouth
115 Forrestview Lane N
Plymouth, MN 55441
763-546-8008

To The Physician:

The Minnesota Department of Health requires all inpatient residents to obtain a comprehensive history and physical assessment thirty (30) days prior to, or within seventy-two hours (3 days) of admission. This form can be used as a guide or actual use. If this guide is not used please provide documents that include all required information below and fax to correlating facility and/or supply to the client for their admission. Please review the list of requirements below and ensure they are documented within the assessment.

Required:

- Physical assessment to include comprehensive health history of client along with a physical exam
- A statement that the client is free from communicable disease, if disease is present, please explain
- A current medication list signed by the provider that includes client name/DOB, medication, dosage, route, time, reason and any parameters recommended.
- Provider to review list of standing orders, change if necessary, and sign/date

Recommended:

- Lab samples including: UA, CBC, STI testing (including RPR, GC and Chlamydia)
- TB screening and administration of a TST, Anthony Louis Center/On Belay RN to read 48-72 hours after placement

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MEDICAL DIRECTOR'S STANDING ORDERS

Client: _____Date of Birth: _____

1. Admit as per Anthony Louis Center / On-Belay House policy.
2. Complete physical examination within three (3) days of admission / initiation service or within thirty (30) days prior to admission / initiation service.
3. Lab work at the time of the physical to include: CBC, Urinalysis, RPR, Gen probe urine GC/Chlamydia.
4. Mantoux (Intermediate strength PPD) to be read in 48 to 72 hours.
5. Vital signs to include: temperature, pulse, respiration, blood pressure, TID for the first 72 hours.
6. Regular diet.
7. Activity as tolerated.
8. Passes and privileges at staff discretion.
9. Eucerin lotion PRN for dry skin. Apply per self.
10. Tylenol 325 mg, two (2) tablets (650 mg.) po q4h PRN for headache, pain, or elevated temperature. Do not exceed 3900 mg./day
11. Mylanta ½ ounce po PRN for upset stomach or heartburn. May repeat x1 two (2) hours later and at HS. Notify M.D. if problem persists.
12. Milk of Magnesia 1 oz. (30 ml.) PRN for constipation. May have up to 2 oz. (60 ml.) daily PRN.
13. Robitussin DM, 2 tsp. q4h PRN po for cough.
14. Cepacol Lozenge for sore throat. PRN q2h.
15. Tinactin Powder applied topically per self PRN as directed for athlete's foot. If no response or open sores develop, notify MD.
16. Anti-fungal cream applied topically per self PRN as directed for athlete's foot.
17. Calamine Lotion PRN topically for itchy rash or insect bites.
18. Bacitracin Ointment PRN for minor abrasions and cuts. Apply topically.
19. Ben-Gay topically per self PRN as directed for minor muscular aches.
20. Hydrocortisone cream 1% for sunburn. Apply topically per self-PRN.
21. Continue oral contraceptive brought in until seen by physician.
22. Anbesol topically to gums PRN– minor tooth or gum aches.
23. Campho-Phenique – bug bites.
24. Sunblock SPF 20 or greater, apply per self topically PRN.

For Vomiting

1. NPO for 4 hours, then 1 oz. sweetened, clear liquid q 10 minutes for 4-8 hours. Advance diet as tolerated.

2. Clear liquids, 1 oz. q 10 minutes until vomiting stops or for a maximum of 18 hours. Advance to bland diet and water. Advance as tolerated.

For Sore Throat

1. Salt water gargle (warm water with 1 tsp. salt) or Cepacol lozenges po PRN.

2. To office for throat culture if problem persists.

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For Acne

1. May continue topical acne medication per self until seen by physician.
2. May continue oral acne medication until seen by physician.
3. Notify M.D. if acne is not being treated by physician or is not responding to present treatment.

_____ _____
Provider's Signature Date

HPI

REVIEW OF SYSTEMS

GENERAL:	NEURO:
HEENT:	PSYCH:
LYMPH NODES:	ALLERGIES:
RESPIRATORY:	FAMILY HX:
CARDIOVSCULAR:	SOCIAL HX:
GI:	SURGICAL HX:
GENITOURINARY:	LMP:
MUSCULOSKELATAL:	GRAVIDA: PARA:
SKIN:	OTHER:

VITALS

T	P	BP	R	HT	WT

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PHYSICAL EXAM

GENERAL:	ABDOMEN:
HEENT	GENITALIA:
NECK:	SPINE:
LYMPH NODES:	EXTREMITIES:
CHEST:	SKIN:
LUNGS:	NEURO:
CARDIOVASCULAR:	PSYCH:

PROVIDER'S NOTE

Diagnosis:
Physical:
Mental:

REQUIRED INFORMATION

***CLIENT IS FREE FROM COMMUNICABLE DISEASE. CHECK YES OR NO**

YES ☐ **NO** ☐ **PLEASE EXPLAIN:**

Signature: _____Date:_____

Clinic facility:_____Phone:_____

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CLIENT MANTOUX REPORT

Identifying Information:

_____, _____ _____

Client's Last Name | Client's First Name | Client's M.I.

To Person Administering T.B. Test:

Either test may be taken. If the Mantoux is interpreted as positive, refer for a chest X-ray.

MANTOUX:

Tuberculin manufacturer: _____ Lot #:_____ Expiration date: _____

Date/Time Implanted: _____Left forearm/Right forearm

_____ _____

Signature/Title Date

Date/Time test was read: _____Results:_____MM induration

Please Circle Interpretation: Positive/Negative

_____ _____

Signature/Title Date

X-RAY OR IGRA

Date Given: _____

Results:_____

_____ _____

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MEDICATION FORM

CLIENT NAME: _____CLIENT DOB: _____

MEDICATION (INCLUDE OTC)	INTSTRUCTIONS (INCLUDE DOSAGE, ROUTE AND TIME)	REASON	SIDE EFFECTS/ADVERSE REACTIONS/ PARAMETERS

PROVIDER'S SIGNATURE: _____DATE:_____