Cayuga MEDICAL CENTER
A Member of Cayuga Health System

BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
05/01/1956 60 F
Ehmke, Clifford BSU 202-01

PHYSICIAN ORDERS - MENTAL HEALTH UNIT

HGT	WGT	DIAGNOSIS:	SENSITIVITIES:
5'7"	150#	psychosis NOS	NKDA

ATTENDING MD:	DIET:	No Caffeine	CODE STATUS: ☐ FULL CODE ☐ SEE DNR ORDER SHEET MUST DOCUMENT:
PRIMARY CARE MD:	ACTIVITY:	OOB Ad Lib	
CONDITION:	VITAL SIGNS:	See Below	

PHARMACY WILL FILL THE DRUG ORDER PER FORMULARY UNLESS OTHERWISE SPECIFIED

DATE	TIME	ORDERS	READ BACK TEL. ORDER
12/25/16	0300	☑ 1) Admit to Mental Health Unit	PF
		☐ 2) CBCD, UA, CHEM PROFILE, TSH, DS3	
		☐ 3) BHCG QUAL (serum pregnancy) on all female patients 50 years old and less.	
		☐ 4) EKG in AM.	
		Dx for EKG purpose:	
		☑ 5) Multivitamin (without iron) 1 tablet PO q 9 a.m. for vitamin supplementation ✓	PF
		☑ 6) Tylenol 650 mg PO Q4H PRN for pain; or temp. > 101°F. ✓	PF
		☑ 7) Mylanta 30 ml PO Q4H PRN for indigestion. ✓	PF
		☑ 8) Vital signs daily unless patient is over 65 years of age then do standing orthostatic	PF
		BP / Q day. Report to physician if BP drops more than 20 mm Hg (systolic)	
		between standing and sitting.	
		☑ 9) Observation status: Q15"	PF
		☑ 10) Begin initial treatment plan.	PF
		☐ 11) MICA Programming	
		☐ 12) Get old records.	
		☐ 13) Plant Intermediate strength Purified Pork Derivative (PPD) intro dermally,	
		read in 48 hrs.	
		Risperdal M-Tab 1mg PO daily ✓	
		☑ **14) Nicotine Replacement**	
		☑ Nicotine Inhaler Q2H PRN Craving	PF
		☑ Nicotine Gum 2 mg PO Q2H PRN Craving	PF
		☑ Apply Nicotine Patch 21 mg QAM, Remove patch at Bedtime	PF
12/25/16	0300	TO: Dr Rahman	

DOCTOR: *USE BALL POINT PEN. PRESS HARD.*

Physician Signature

12/25/16 5PM
Date / Time

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TELEPHONE / VERBAL ORDERS

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Date: 1-1-17 Time: 710

Medication Name	Dose	Route	Frequency	PRN?	Indication (required for PRN) Include parameters if applicable
Thorazine	100mg	PO	x1	☐Y ☐N	Stat
if patient refuses,				☐Y ☐N	
give:				☐Y ☐N	
Thorazine	100mg	IM	x1	☐Y ☐N	
				☐Y ☐N	

Tests and Labs	Reason

All Other Orders

☒ Telephone Order ☐ Verbal Order

Provider	Taken & Read Back By
Name: (Print) Dr. Ehmke	Name: (Print) Shannon Aether
Orders will be electronically signed by the provider. *One set of telephone orders per order form.* *Cross off unused lines.*	Signature / Title: Shaether RN Telephone Number: 4304

Orders entered by: _____ Date: _____ Time: _____

Chart checked by: _____ Date: _____ Time: _____

White - Chart Canary - Pharmacy

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PHYSICIAN ORDERS

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A00082793308 M000597460
05/01/1956 60 F
Ehmke, Clifford BSU 202-01

HGT	WGT	DIAGNOSIS:	SENSITIVITIES:
5'7"	150#	Psychosis NOS.	NKDA

ATTENDING MD:	DIET:	CODE STATUS: ☐ FULL CODE ☐ DNR / MOLST ☐ MOLST E ☐ DNR
PRIMARY CARE MD:	ACTIVITY:	
CONDITION:	VITAL SIGNS:	

MEDICATIONS PER FORMULARY UNLESS OTHERWISE SPECIFIED

DATE	TIME	ORDERS	INDICATION/REASON
		☐ OBV / Outpatient ☐ Admit Inpatient	
		☐ See DVT Prophylaxis Form ☐ See Anti-Coagulation Treatment Form	
		☐ See Medication Reconciliation Sheet	
		Call Physician if HR > _____ or < _____, SBP > _____ or < _____,	
		Temp > _____, O_2Sat < _____	
12/25/16	2305	24° ✓ chart electronically reviewed ~ Michelle Bowman	
12/26/16	2350	24° ✓ chart electronically reviewed ~ Michelle Bowman	
12/27/16	2335	24° ✓ chart electronically reviewed ~ Shan Sei LPN	
12/28/16	2351	24° ✓ Chart electronically reviewed Haley Burr, RN	
12/30/16	0005	24° ✓ chart electronically reviewed ~ Shan Sei LPN	
12/30/16	2325	24° ✓ chart electronically reviewed ~ Michelle Bowman	
1/1/17	0305	24° ✓ chart electronically reviewed ~ Shan Sei LPN	
1/2/17	0005	24° ✓ chart electronically reviewed ~ Shan Sei LPN	
1/6/17	2310	24° ✓ chart electronically reviewed ~ Michelle Bowman	
1/4/17	0100	24° ✓ Chart electronically reviewed - BNIVEE RN	
1-4-17	2342	24° electronic chart reviewed JpCole RN	
1/6/17	0018	24° ✓ Chart electronically reviewed - Haley B. RN	
1/7/17	0006	24° ✓ Chart electronically reviewed - BNIVEE RN	
1/7/17	2330	24° ✓ chart electronically reviewed ~ Michelle Bowman	
1/8/17	2242	24° ✓ chart electronically reviewed ~ Michelle Bowman	
1/9/17	2352	24° ✓ chart electronically reviewed - BNIVEE RN	
1/1/17	0030	24° ✓ chart electronically reviewed - BNIVEE RN	
1/12/17	0047	24° ✓ Chart electronically reviewed - Haley Burr, RN	
1/13/17	2341	24° ✓ Chart electronically reviewed - Haley Burr, RN	
1/14/17	0239	24° ✓ chart electronically reviewed Haley Burr, RN	

Physician Signature: _____ Date / Time: _____

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TELEPHONE / VERBAL ORDERS

BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
05/01/1956 60 F
Ehmke, Clifford BSU 202-01

Date: 1-19-17 Time: 1002

Medication Name	Dose	Route	Frequency	PRN?	Indication (required for PRN) Include parameters if applicable
				☐Y ☐N	
				☐Y ☐N	
				☐Y ☐N	
				☐Y ☐N	
				☐Y ☐N	

Tests and Labs	Reason

All Other Orders

Please hold tonight's (1-19-17) HS dose of Geodon. Please resume Geodon HS on 1-20-17

☒ Telephone Order ☐ Verbal Order

Provider	Taken & Read Back By
Name: (Print) DR. Ehmke	Name: (Print) Shannon Leather
Orders will be electronically signed by the provider. *One set of telephone orders per order form.* *Cross off unused lines.*	Signature / Title: Sleather RN
	Telephone Number: 4304

Orders entered by: _____ Date: _____ Time: _____

Chart checked by: _____ Date: _____ Time: _____

White - Chart Canary - Pharmacy

Cayuga MEDICAL CENTER
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TELEPHONE / VERBAL ORDERS

Pat
BLAYK, BONZE ANNE ROSE
Date 00082793308 M000597460
01/1956 60 F
Ke, Clifford BSU 202-01

Date: 01/22/17 Time: 2324

Medication Name	Dose	Route	Frequency	PRN?	Indication (required for PRN) Include parameters if applicable
Haldol	5mg	Po or IM	X 1	☐Y ☒N	(Po given 2328)
Benadryl	50mg	Po or IM	X 1	☐Y ☒N	(Po given 2328)
				☐Y ☐N	
				☐Y ☐N	
				☐Y ☐N	

Tests and Labs	Reason

All Other Orders

may utilize therapeutic hold if necessary.

☐ Telephone Order ☒ Verbal Order

Provider	Taken & Read Back By
Name: (Print) Dr. Rahman	Name: (Print) Michele Brown RN
Orders will be electronically signed by the provider. *One set of telephone orders per order form.* *Cross off unused lines.*	Signature / Title: Michele Brown RN Telephone Number: 607-274-4304

Orders entered by: _____ **Date:** _____ **Time:** _____

Chart checked by: _____ **Date:** _____ **Time:** _____

White - Chart **Canary** - Pharmacy

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PHYSICIAN ORDERS

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PRIMARY CARE MD:	ACTIVITY:	
CONDITION:	VITAL SIGNS:	

MEDICATIONS PER FORMULARY UNLESS OTHERWISE SPECIFIED

DATE	TIME	ORDERS	INDICATION/REASON
		☐ OBV / Outpatient ☐ Admit Inpatient	
		☐ See DVT Prophylaxis Form ☐ See Anti-Coagulation Treatment Form	
		☐ See Medication Reconciliation Sheet	
		Call Physician if HR > _____ or < _____, SBP > _____ or < _____,	
		Temp > _____, O_2Sat < _____	
1/14/17	2341	24° Chart electronically reviewed - BNIVER RN	
1/16/17	0030	24° / chart electronically reviewed — Ghana Jenis LPN	
1/16/17	2350	24° / chart electronically reviewed ~ Michelle Bromley	
1/17/17	2300	24° Chart electronically reviewed ~ Michelle Bromley	
1/19/17	0016	24° Chart electronically reviewed. Hay — Burg, RN	
1/20/17	0019	24° Chart electronically reviewed, Haley Burg, RN	
1/21/17	2335	24° Chart electronically reviewed. Haley Burg RN	
1/22/17	0400	24° chart electronically reviewed - Cmonk RN	
1/22/17	2337	24° / chart electronically reviewed ~ Michelle Bromley	
1/23/17	2330	24° / chart electronically reviewed ~ Michelle Bromley	
1/25/17	0015	24° / chart electronically reviewed ~ Ghana Jenis LPN	
1/26/17	0005	24° chart electronically reviewed - Cmonk RN	
1/27/17	0105	24° chart electronically reviewed - Cmonk RN	
1/28/17	0055	24° / Chart electronically reviewed - BNIVER RN	
1/30/17	0233	24° / Chart electronically reviewed - BNIVER RN	
1/31/17	0125	24° chart electronically reviewed - Cmonk RN	
2/1/17	0005	24° chart electronically reviewed - Cmonk RN	
2/1/17	2335	24° / chart electronically reviewed, Haley Burg, RN	
2/2/17	2335	24° / Chart Electronically Reviewed K. Smith RN	
2/3/17	2320	24° / Chart electronically reviewed. Haley Burg, RN	

Physician Signature: _____ Date / Time: _____

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		☐ See DVT Prophylaxis Form ☐ See Anti-Coagulation Treatment Form	
		☐ See Medication Reconciliation Sheet	
		Call Physician if HR > _____ or < _____, SBP > _____ or < _____,	
		Temp > _____, O_2Sat < _____	
2/5/17	0200	24' chart electronically reviewed - CmonRN	
2/5/17	2355	24°√ chart electronically reviewed ~ Michelle Bonnell RN	
2/6/17	2337	24°√ Chart Electronically Reviewed ~ Kevin ~~Bonnell~~ RN	
2/7/17	2343	24°√ Chart Electronically Reviewed ~ ~~Bonnell~~ RN	
2/8/17	2341	24°√ Chart electronically reviewed, Hale Bes, RN	
2/10/17	0200	24' chart electronically reviewed - CmonRN	

Physician Signature: _____ Date / Time: _____

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Addressograph

Physician Certification & Re-Certification

Initial Certification
Due Date: ____/____/____

I certify that the inpatient psychiatric hospital admission is medically necessary because:
For patient's & others' safety & stabilization of acute symptoms.

I estimate 10 days/____ weeks of hospitalization are necessary for treatment of this patient.

My plans for post hospital care for this patient are:
☐ Home ☐ Office Care ☐ Home Health Agency
☒ Extended Care ☐ Nursing Home
☐ Other: _____

_____ 12/25/16 5PM
Attending Physician Date

1st Re-Certification
Day 12
Due Date: ____/____/____

I certify that the inpatient hospital services furnished since the previous certification were, and continue to be, medically necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study and that the hospital records indicate that the services furnished were, either, intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

I estimate ____ days/____ weeks of hospitalization are necessary for treatment of this patient.

My plans for post hospital care for this patient are:
☐ Home ☐ Office Care ☐ Home Health Agency
☐ Extended Care ☐ Nursing Home
☐ Other: _____

_____ _____
Attending Physician Date

BLAYK, BONZE ANNE ROSE
A00082793308 M000597460
05/01/1956 60 M
ED

Physician Re-Certification (cc

Every 30 Days After 2nd Certification

I certify that the inpatient hospital services furnished since the previous certification were, and continue to be, medically necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study and that the hospital records indicate that the services furnished were, either, intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

2nd Re-Certification
Day 18
Due Date: ____/____/____

I estimate _____ days/_____ weeks of hospitalization are necessary for treatment of this patient.

My plans for post hospital care for this patient are:
☐ Home ☐ Office Care ☐ Home Health Agency
☐ Extended Care ☐ Nursing Home
☐ Other:_____

Attending Physician Date

I certify that the inpatient hospital services furnished since the previous certification were, and continue to be, medically necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study and that the hospital records indicate that the services furnished were, either, intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

Re-Certification
Day 30
Due Date: ____/____/____

I estimate _____ days/_____ weeks of hospitalization are necessary for treatment of this patient.

My plans for post hospital care for this patient are:
☐ Home ☐ Office Care ☐ Home Health Agency
☐ Extended Care ☐ Nursing Home
☐ Other:_____

Attending Physician Date