SEQUOIA
Integrative Medical Services

Patient Communication Tool

Patient Name: **Facility Name:**

DOB:

Brief summary of primary problem:

Date of onset:

Relevant data **(Recent falls, med changes, illness, etc.)**

CURRENT Vital Signs: BP _____ P _____ RR _____ T _____O2 _____ Pain _____

List any prn medications used for relief of reported concern:

Recent Injury/Incident/Fall (Please include facility fall report):

Refill Request -

Medication Name & Strength:

Directions:

Inquiry (Referrals, Family requests, Med Adjustment Requests) - Please note below & include reasoning:

Other:

Facility Staff/Nurse/Manager Competing Form:

Print Name: _____ **Date:** _____

Best Contact Information for Follow Up:

Phone #: _____ **Fax:** _____ **Other:** _____

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Facility Checklist for Visit

Please have the following information completed prior to the Sequoia Team arriving at your community.

- ☐ Complete 'Rounding Form' or comparable document including:
  - ☐ Patient Name
  - ☐ Date of Birth
  - ☐ Room Number
    - ☐ Vital Signs (***Please note:*** Vital signs are to be documented for every patient at every visit. Vital signs do not need to be taken the same day, may be obtained in advance. Monthly vitals are accepted).
      - ☐ Weight
      - ☐ Blood Pressure
      - ☐ Pulse
      - ☐ Respirations
      - ☐ O2
      - ☐ Temperature
      - ☐ If Diabetic, please include past 14 days of blood sugars.
  - ☐ Include **PRINTED COPY** of current medications - Copies of MAR or printed face sheet with medications are accepted.
- ☐ Concerns
  - ☐ Please document any concerns, questions or requests in the space provided.
  - ☐ If there are no concerns for the patient, please indicate this in the space provided.
    - ☐ **Pease include:**
      - ☐ Home Health/Hospice Services patient receives.
      - ☐ Specialty appointments patient has attended since previous visit.
      - ☐ Recent labs obtained.
      - ☐ Other needs: DNR, Incompencency, Advanced Directives, etc.
- ☐ Family members who wish to be present, family members who wish to receive a phone call during visit, please include a time they plan to be present.
    - ☐ ***Please notify our team PRIOR to scheduled visit of family planning to be present/receive a phone call, this ensures appropriate planning.***
      - ☐ **We cannot guarantee set times**
- ☐ Nursing staff available for questions.

Thank you for assisting us in providing patient care!

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Communication during and between Sequoia patient visits…

PLEASE FAX OR CALL TO REPORT PATIENT NEEDS

Faxing Patient Concern(s):

- Include CURRENT vital signs
- Please indicate whether notification is as an FYI or action item.
- If updating on a change in status (weight gain, High blood pressure), include patients normal range/status and current medications patient is on.
- In general, please be detailed. Our team is not present in the community to assess the patient. Subjective and objective data is necessary for appropriate decision making.

Medication/Orders

- Please include as much detailed data for medication change requests/concerns.
- When requesting a controlled substance over the Bridge please include the pharmacy phone/fax number, current dose, and directions.

When to Update Sequoia

- When patients pass away, please include time and date
- ● For care transitions:
    - Going out: for example, being sent to the hospital - Time sent out, hospital, and reason.
    - Returning: please let us know when they return, **request Dictated Discharge Summary for continued care.**
    - Please provide all documents obtained to our team fax!
    - When patients start on hospice or home care services, what agency are they using?
    - Anything acute that occurs that requires addressing.

New Patients

- When faxing admission paperwork, please include information from prior health care providers; at minimum we require a recent visit note/H&P, labs and medications. The more info the better!
- Please send the medical health care directive/medical POA paperwork/Code Status with admission paperwork, and signed release of information.
- Please have the patient’s electronic facility chart available.

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Telephone Triage/Message Form

Message taken by:		
Date:	Time:	
Caller's Name:	Relationship to Patient:	
Ph #:	Fax #:	
Patient Name:	DOB:	Facility:
Problem/Patient Complaint/Reason for Call:		
BP _____ P _____ R _____ T _____ O _____ W _____		
Medication Refill:	Medication:	
Pharmacy Name:	Ph/Fax #:	

Order(s) Provided / Med Refilled / Referral / Med Review / Other:

_____

Nurse Signature: _____ Date: _____