SEQUOIA
Integrative Medical Services

PATIENT COMMUNICATION TOOL

Name _____ DOB: _____

Facility Name: _____

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 completing form:

Print Name: _____ Date: _____

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 the 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.
  - ☐ Please include:
    - ☐ Home Health/Hospice Services patient receives
    - ☐ Specialty appointments patient has attended since previous visit
    - ☐ Recent labs obtained
    - ☐ Other needs: DNR, Statement of Incapacity, Advanced Directives, etc.
- ☐ Family members who wish to be present, or 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. Please note, we cannot guarantee set times.
- ☐ Nursing staff available for questions.

Thank you for assisting us in providing patient care!

Central WI
Fax: (920) 543-5288
Triage: (920) 422-7074

Western WI
Fax: (715) 520-5288
Triage: (920) 372-4268

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COMMUNICATION DURING & 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 patient's 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 healthcare providers; at minimum we require a recent visit note/H&P, labs and medications. The more info, the better!
- ☐ Please send the medical healthcare directive/medical POA paperwork/Code Status with admission paperwork, and signed release of information.
- ☐ Please have the patient's electronic facility chart available.
- ☐ For the full admission checklist, please see the **New Patient Checklist.**

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TELEPHONE TRIAGE/MESSAGE FORM

Message taken by: _____ Date: _____ Time: _____

Caller's name: _____ Relationship to patient: _____

Phone number: _____ Fax number: _____

Patient's name: _____ DOB: _____ Facility: _____

Problem/Patient Complaint/Reason for Call: _____

_____

_____

_____

BP: _____ P: _____ R: _____ T: _____ O: _____ W: _____

Medication Refill: _____ Medication: _____

Pharmacy: _____ Phone/Fax: _____

Order(s) provided: ☐ Med Refilled ☐ Referral ☐ Med Review ☐ Other: _____

Nurse Signature: _____ Date: _____