

**INPATIENT PROGRAM STANDING ORDERS**

Patient Name _____ DOB _____		
<p><b>Diet Choices:</b> Per nursing home regulations, residents will receive a <b>REGULAR</b> diet. Bailey-Boushay House Dietician will provide education regarding therapeutic diet recommendations.</p>	<p><b>Therapies:</b></p>	
<p><b>Texture</b> (Check one)</p> <p><input type="checkbox"/> Regular</p> <p><input type="checkbox"/> Dysphagia Advanced</p> <p><input type="checkbox"/> Dysphagia Mechanically Altered</p> <p><input type="checkbox"/> Dysphagia Pureed</p>	<p><b>Thin/Thickened Liquids?</b> (Check one)</p> <p><input type="checkbox"/> Thin</p> <p><input type="checkbox"/> Nectar</p> <p><input type="checkbox"/> Honey</p> <p><input type="checkbox"/> Spoon</p>	<p><input checked="" type="checkbox"/> OT</p> <p><input checked="" type="checkbox"/> PT</p> <p><input type="checkbox"/> Speech</p> <p><input checked="" type="checkbox"/> Recreation</p> <p><input type="checkbox"/> Respiratory</p>
<p><b>Follow Virginia Mason Medical Center/Bailey-Boushay House policies for care and management of the following, unless ordered otherwise.</b></p> <p>Central line/midline              For <b>all</b> patients with central lines:              Cathflo activase 2 mg intra-catheter solution.              2mg IV 4x/week PRN clogged line; may administer second dose in 2 hours if initial dose ineffective.</p> <p>Ostomy          PEG/G-tube          Foley and suprapubic catheters          General wound care</p>		
<p><b>Evaluation of MTB:</b> Admitted Residents <b>must</b> be evaluated for presence of active TB as required by WAC 388-97-1400/1440. Bailey-Boushay House will provide a 2-step PPD. If there is a documented history of a past positive result, CXR to r/o active TB and monthly symptom checks will be ordered per protocol.  <b>Please note any history of TB or reactive PPD here.</b></p>		
<p><b>Vaccine History:</b></p> <p>Annual Flu Vaccine                      Date: _____              <b>[During influenza season: current flu season vaccination unless contraindicated or already given.]</b></p> <p>Pneumococcal Vaccine                  PCV13 Date: _____                  PPSV23 Date: _____</p> <p>Tdap Vaccine                              Date: _____</p> <p>COVID-19 Vaccine                      Brand: _____                  Date(s): _____</p>		
<p>MD/ARNP Printed Name _____</p> <p>DEA # _____                      NPI # _____</p> <p>MD/ARNP Signature _____                  Date _____</p>		