FLINT

Admission Packet

McLaren Flint

Two-Midnight Stay Certification

Please place in Progress Notes

☐ ***Admit to Inpatient care:*** Based on my medical assessment, after consideration of patient's risk factors – age, co-morbidities and patient presenting symptoms and acuity – I expect that this patient will remain in the hospital at least two midnights or that the ***services*** needed ***warrant*** inpatient care because:

Specify patient risk factors/co-morbidities______________________________________

____

Anticipated diagnostic tests, treatment, and/or procedures _______________________

____

****Note: H&P and Progress Notes should support this documentation***

Patient is currently Observation status

☐ ***Observation Advancing to Admit to Inpatient Care***

There are continued needs for hospital care beyond the observation period due to:

____

Service provided (acuity): ____

I certify that my determination is in accordance with my understanding of Medicare's requirements for reasonable and necessary inpatient services (42 CFR 412.39e)

___________________________	_____/_____	___________________________
Physician Signature	Date Time	Supervising Physician *(If appropriate)*

☐ ***Patient remains Observation appropriate & will be discharged today.***

Utilization Management Department

_____________________________ RN, UR Nurse 810-342-3030

UM Manager 810-342-2355

UM Director 810-342-2423

Two-Midnight Stay Certification

17897 7/14 (Intranet)

180b

PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan

Patient Information Number (PIN) Program Acknowledgement Form

Nursing Instructions:

1. Enter the PIN on the card.

2. Provide the PIN card to the patient or their spokesperson.

3. Advise the patient or their spokesperson that they may share this PIN with anyone they wish to be able to obtain information on the patient's condition.

4. Advise the patient or their spokesperson that the staff will NOT provide the PIN to anyone on their behalf.

5. Obtain the patient's or their spokesperson's signature on the PIN acknowledgement form. The form will be maintained as part of the patient's record.

Patient/Spokeperson Acknowledgement for Receipt of PIN Card

By signing this form, I acknowledge:

1. Receipt of the Patient Identification Number Card with PIN.

2. That I understand that the distribution of this number is solely my responsibility.

3. That the staff of McLaren Flint will not provide this number to anyone, even if expressly directed to do so by me.

4. That the staff of McLaren Flint will not release any information without being accurately provided with the PIN.

_______________________________________ _______________

Signature of Patient or Patient's Spokesperson   Date

Attachment A

820b

PT.

MR.#/P.M.

DR.

Passport to Transport

* Use pencil

Transport Mode: Bed: ___ Bari Bed: ___ WC: ___ Bari WC: ___ Stretcher: ___ Other: _________

Activity: ______________________ **Isolation:** ______________

Lines:	**O2:**	**Fall risk:**	**Monitor:**	**Neuro:**
AV FISTULA ___	Yes ___	Red ___	Yes ___	Alert ___
VAS CATH ___	No ___	Yellow ___	No ___	Oriented ___
NGT/OGT ___		Green ___		Confused ___
FOLEY ___				Lethargic ___
CVC ___	**IV:**	**Code Status:**		Deaf ___
PICC ___	Yes ___	Full ___		Blind ___
	No ___	No code ___ (see chart)		

Allergies: ______________________________

Important info: ______________________________

Date:	**Procedure:**	**Initials:**

Pt ID Stamper

Patient Identification Number (PIN) Program
Protecting Your Privacy

Your privacy is very important to us. At the same time, we want to make sure your experience at McLaren Flint is a positive one, and we realize how important family and loved ones are during any hospital stay.

We have established the Patient Identification Number (PIN) Program to help manage our commitment to your privacy; along with your family and loved ones need for information to help in your recovery process.

(cut along dotted line)

FLINT

mclaren.org

The PIN **DOES NOT** allow family members or loved ones access to obtain copies from your medical records. The code is also only valid for this specific admission. **Future admissions require a new PIN.**

If you have any questions regarding the PIN program, please feel free to talk with your nurse.

Below is your visit specific PIN. You may share this number with whomever you wish.

The type of information that will be shared by Nursing staff to individuals providing a correct PIN is the Basic Patient Information. Basic Patient Information is related to your general well being, surgeries/tests/procedures which have been scheduled and completed; and that results/outcomes are available for discussion with your physician.

Our discharge goal is 11:00 a.m. on the day of discharge. Please be sure to let the nurse know who will be picking up your loved one. Be sure to contact the floor nurse if there are any questions or concerns that we may help with. Thank you for choosing McLaren Flint

Due to patient confidentiality, in order for your family to obtain information about your health condition over the phone or in person, the PIN provided below must be communicated to the Nurse, prior to release of any health information. Please make sure anyone that you want to have access to Basic Patient Information has been given this number.

PIN: ______________________

PIN: ________________________

Admission Date: ____/____/____

McLAREN FLINT
Flint, Michigan

PATIENT BELONGINGS INVENTORY

ARTICLES OF CLOTHING BROUGHT TO HOSPITAL

	Bathrobe		Dress		Jeans/pants		Slippers/Socks		Sweater
	Belt		Nightgown		Shirt		Shoes/Boots		Sweatpants
	Bra		Hat		Pajamas		Skirt		Sweatshirt
	Coat/Gloves		Jacket		T-Shirt		Underwear		Other: ____________

Other:

VALUABLES BROUGHT TO HOSPITAL

	Hearing Aid ____Right ____Left		Walker/Cane		Dentures ___Upper ___Lower		Jewelry		Purse
			Braces/Splints						Wallet
							Keys		**Money** **$_____.___** **# of Credit Cards ____** ☐Sent Home ☐Cashier Envelope #:__________
	Cell Phone/ Charger		Prosthetics __________ __________		Medication ☐Sent Home ☐Pharmacy		Eye Wear ____Glasses ____Contacts		
	Lap Top								
	Other:								

Other: ***Denotes items secured on Unit**

I have read the following and acknowledge:

- **McLaren-Flint will not be liable (responsible) for any money or property of any kind retained by me or kept in my possession while I am at the hospital.**
- Please take all Valuables home when possible.
- **After 60 DAYS McLaren-Flint will dispose of all unclaimed property left at the Medical Center**. Please call Security at (810) 342-3333, to claim any valuables after discharge.

Patient Signature: ______________________________ Date: _____/_____/_____

Time: _______am / pm ☐ Patient ☐ Responsible Party Relationship (to patient): ______________

Sending Unit: _____ Receiving Unit: _____ Nursing Staff Signature: ______________________

Signature NOT Obtained Because: ______________________________ ☐ DOA

☐ Patient has no belongings or belongings sent home with Patient Family or Representative.

PATIENT TRANSFER BELONGING INFORMATION

Clothing & Valuables with Patient as Indicated Above **☐Yes ☐No** **From room#: ________** **To room #: ________**	Date:____ Initials____ Changes listed below: ________ ________ ________ ________	**Clothing & Valuables with Patient as Indicated Above** **☐Yes ☐No** **From room#: ________** **To room #: ________**	Date:____ Initials____ Changes listed below: ________ ________ ________ ________
Clothing & Valuables with Patient as Indicated Above **☐Yes ☐No** **From room#: ________** **To room #: ________**	Date:____ Initials____ Changes listed below: ________ ________ ________ ________	**Clothing & Valuables with Patient as Indicated Above** **☐Yes ☐No** **From room#: ________** **To room #: ________**	Date:____ Initials____ Changes listed below: ________ ________ ________ ________

For use by Security only:

☐ Contraband/Weapon(s) (Guns, Knives and any Object similarly used): ______________________

Security Signature: ______________________ Date: ____/____/____ Envelope #: ________

☐ All of my belongings have been returned to me.

Patient Signature: ______________________ Date: ______________________

WHITE - Medical Records
CANARY - Patient at Discharge
PINK - Patient at Admission

PATIENT BELONGINGS INVENTORY

3805 (1/14)

870b

PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan

PATIENT BELONGINGS INVENTORY

ARTICLES OF CLOTHING BROUGHT TO HOSPITAL

	Bathrobe		Dress		Jeans/pants		Slippers/Socks		Sweater
	Belt		Nightgown		Shirt		Shoes/Boots		Sweatpants
	Bra		Hat		Pajamas		Skirt		Sweatshirt
	Coat/Gloves		Jacket		T-Shirt		Underwear		Other: ___________________

Other:

VALUABLES BROUGHT TO HOSPITAL

	Hearing Aid ____Right ____Left		Walker/Cane		Dentures ___Upper ___Lower		Jewelry		Purse
			Braces/Splints						Wallet
							Keys		**Money** **$_____.___**
	Cell Phone/ Charger		Prosthetics _______________ _______________		Medication □Sent Home □Pharmacy		Eye Wear ____Glasses ____Contacts		**# of Credit Cards ____** □Sent Home □Cashier Envelope #:___________________
	Lap Top								
	Other:								

Other: ***Denotes items secured on Unit**

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Patient Signature: ____Date: _____/_____/_____
Time: _______am / pm □ Patient □ Responsible Party Relationship (to patient): ________________
Sending Unit: _____ Receiving Unit: _____ Nursing Staff Signature: ______________________________
Signature NOT Obtained Because: ____ □ DOA
□ Patient has no belongings or belongings sent home with Patient Family or Representative.

PATIENT TRANSFER BELONGING INFORMATION

Clothing & Valuables with Patient as Indicated Above **□Yes □No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:	**Clothing & Valuables with Patient as Indicated Above** **□Yes □No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:
Clothing & Valuables with Patient as Indicated Above **□Yes □No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:	**Clothing & Valuables with Patient as Indicated Above** **□Yes □No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:

For use by Security only:
□ Contraband/Weapon(s) (Guns, Knives and any Object similarly used): ______________________________
Security Signature: _________________________________ Date: ____/____/____ Envelope #: _________

□ All of my belongings have been returned to me.
Patient Signature: ____ Date: ______________________________

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PATIENT BELONGINGS INVENTORY
3805 (1/14)

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McLAREN FLINT
Flint, Michigan

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	Bra		Hat		Pajamas		Skirt		Sweatshirt
	Coat/Gloves		Jacket		T-Shirt		Underwear		Other: ____________________

Other:

VALUABLES BROUGHT TO HOSPITAL

	Hearing Aid ____Right ____Left		Walker/Cane		Dentures ___Upper ___Lower		Jewelry		Purse
			Braces/Splints						Wallet
							Keys		**Money** **$_____.___**
	Cell Phone/ Charger		Prosthetics _______________ _______________		Medication ☐Sent Home ☐Pharmacy		Eye Wear ____Glasses ____Contacts		**# of Credit Cards ____** ☐Sent Home ☐Cashier Envelope #:__________________
	Lap Top								
	Other:								

Other: ***Denotes items secured on Unit**

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Time: _______am / pm ☐ Patient ☐ Responsible Party Relationship (to patient): ________________
Sending Unit: _____ Receiving Unit: _____ Nursing Staff Signature: ____________________________________
Signature NOT Obtained Because: ____ ☐ DOA
☐ Patient has no belongings or belongings sent home with Patient Family or Representative.

PATIENT TRANSFER BELONGING INFORMATION

Clothing & Valuables with Patient as Indicated Above ☐**Yes** ☐**No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:	**Clothing & Valuables with Patient as Indicated Above** ☐**Yes** ☐**No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:
Clothing & Valuables with Patient as Indicated Above ☐**Yes** ☐**No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:	**Clothing & Valuables with Patient as Indicated Above** ☐**Yes** ☐**No** **From room#: _________** **To room #: _________**	Date:____ Initials____ Changes listed below:

For use by Security only:

☐ Contraband/Weapon(s) (Guns, Knives and any Object similarly used): ______________________________
Security Signature: ________________________________ Date: ____/____/____ Envelope #: _________

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Patient Signature: ____ Date: ______________________________

WHITE - Medical Records
CANARY - Patient at Discharge
PINK - Patient at Admission

PATIENT BELONGINGS INVENTORY
3805 (1/14)

870b

PT.

MR.#/P.M.

DR.

PT.

MR.#/RM.

DR.

FLINT

NO SMOKING POLICY NOTIFICATION AND AGREEMENT

To provide an environment that promotes wellness for patients, visitors, employees, volunteers, and medical staff members, and to recognize the harmful effects associated with smoking, McLaren-Flint has adopted a non-smoking policy.

This policy is based on regulations and directives of the Joint Commission on Accreditation of Health Organizations, Michigan Department of Public Health and the Michigan Public Health Code and Michigan State Law (P.A. 315, 1988, Sec. 12604 @ (2)(a).

Smoking and tobacco use is not permitted in any McLaren owned or leased vehicles, or on property that is owned, leased or under the control of McLaren, including, but not limited to; parking lots, parking ramps, walkways, buildings, and vehicles (Ref. HR Policy-130).

Patients and Visitors:

1. Patients and visitors will be informed of the non-smoking status through pre-admission procedures, documents in the admission packet, and signage throughout McLaren-Flint's facilities.

2. Because caregivers are not able to monitor patients when they are outside of the building, patients may not leave the building to smoke while they are hospitalized at McLaren Flint. **Patients who violate this rule and leave the building to smoke do so at their own risk. The hospital is not liable for injuries or harm that may occur as a result of this action. Any damage to hospital equipment will be the patient's responsibility.**

3. If a patient is observed smoking or requests to smoke, Nursing Management will be notified. If the patient continues to smoke, then the patient's attending physician will be notified and hospital equipment will be discontinued.

Patient or Legal Designee Please Read and Sign

I agree to abide by McLaren Flint's non-smoking policy. While I am a patient at McLaren-Flint, I will refrain from smoking. I understand that if I choose to violate this policy, McLaren Flint will notify my attending physician. I understand that I can request nicotine withdrawal medication.

______________________________ ______________________________

Patient or Legal Designee Witness

____

Date

820b

McLAREN
FLINT

PATIENT DISCHARGE CHECKLIST

To be completed as part of the discharge process for all patients

- ❑ **RN verifies discharge medications match physician order sheet/TMO;**

  Verifying RN Signature____________________________.
- ❑ Pneumovax given/refused/contraindicated; documented in Paragon
- ❑ Influenza Vaccination given/refused/contraindicated; documented in Paragon

FOR THE FOLLOWING CORE MEASURES:

ACUTE MI / NSTEMI ❑ *N/A*

- ❑ Aspirin or documented contraindication
- ❑ Beta Blocker or documented contraindication
- ❑ Statin if LDL ≥100 or documented contraindication
- ❑ ACS/MI Education Materials given and documented
- ❑ ACE or ARB if EF<40% or documented contraindication; may take verbal order

HEART FAILURE ❑ *N/A*

(Includes primary or secondary admitting diagnosis of CHF)

- ❑ Echo report or documented EF
- ❑ Heart Failure Education materials given/documented
- ❑ ACE or ARB if EF<40% or documented contraindication; may take verbal order

STROKE / TIA ❑ *N/A*

- ❑ Antithrombotic or documented contraindication
- ❑ Anticoagulant for Afib/Aflutter patients or documented contraindication
- ❑ Statin if LDL ≥100 or documented contraindication
- ❑ Rehab Assessment (PT/OT/Speech)
- ❑ Stroke Education:
  - Printed Stroke packet/info given
  - Risk factors of a Stroke
  - Warning Signs/Symptoms of a Stroke
  - Activation of EMS/911
  - Follow up appts.

I verify that the following activities have been completed prior to discharge:

RN Signature: ____________________________________ Date: _______________

PATIENT DISCHARGE CHECK LIST

17343 Rev. 4/14 (Intranet)

780b

PT.

MR.#/VID#

DR.

McLaren Flint
Physician Discharge Readiness Communication Checklist

Date __________ Time __________

Patient Name_____________________ Expected Discharge Date: ______________

Please sign/date and time if patient is cleared for discharge by your service:

- **Behavioral Health (Sign/Date/Time) _____________________**
- **Cardiology (Sign/Date/Time) __________________________**
- **Infectious Disease (Sign/Date/Time) ____________________**
- **Nephrology (Sign/Date/Time) _________________________**
- **Neurology (Sign/Date/Time) __________________________**
- **OB/Gynecological Services (Sign/Date/Time) ____________**
- **Orthopedics (Sign/Date/Time) ________________________**
- **Primary Care Physician (Sign/Date/Time) ______________**
- **Pulmonology (Sign/Date/Time) ________________________**
- **Surgery (Sign/Date/Time) ____________________________**
- **Urology (Sign/Date/Time) ____________________________**
- **Vascular (Sign/Date/Time) ____________________________**
- **Other (Sign/Date/Time) ______________________________**

Discharge Disposition:

- **Home and/or with family ____**
- **In-patient Rehab ____**
- **ECF and/or Short term Rehab ____**

Home Care Coordination:

- **Eval requested (order written) ____**
- **Services needed/Comments:**

____

____

____