FLINT

Inpatient Rehab Admission Packet

M-2946 (6.19)

Telephone
You will have your own phone in your room:

- Your room phone number will be posted on your communication board
- Local calls: Dial 9 + local number (Free local calls)
- Long distance calls: Dial 9+0+area code + number (Cannot be charged to room)
- Out-of-town friends may call you toll-free at 1.800.821.6517
- You may use a cell phone in your room. Please bring your charger.

Free WiFi
Please enjoy your personal phone or computer with McLaren's free Wi-Fi. (May require disclaimer agreement when signing on.)

Visiting Hours
8 am–8 pm

Parking
Free parking for one visitor is available. Please see your recreation therapist or social worker for additional information.

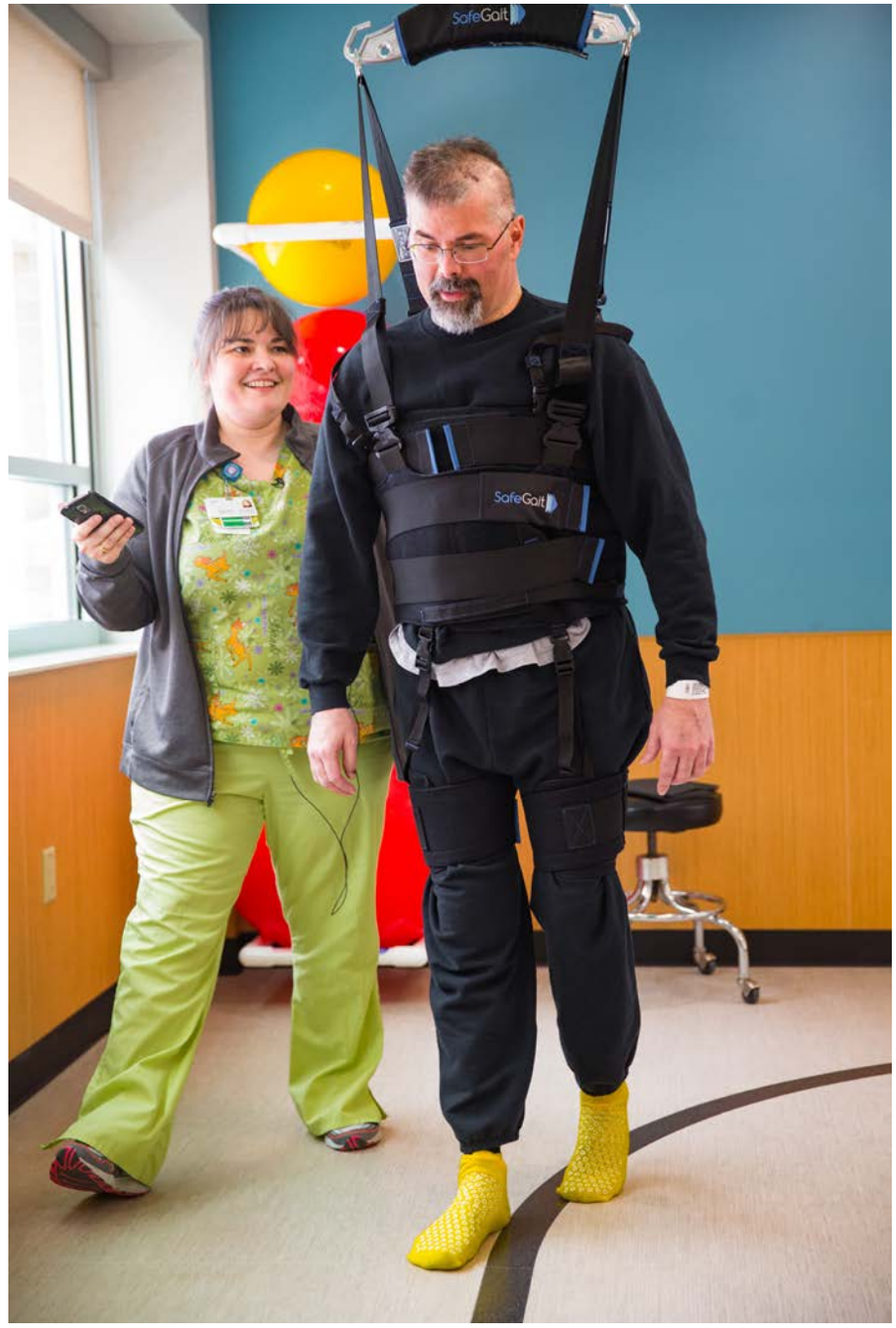
YOUR RIGHTS

Patients have rights and responsibilities. McLaren has the responsibility to provide ethical treatment and service. We value your opinion and welcome your comments, concerns and complaints. For any questions or concerns during your stay, please contact the rehabilitation social worker or manager.

Thank you again for choosing us for your inpatient rehabilitation needs

McLaren Flint Inpatient Rehabilitation Facility
401 S. Ballenger Highway | Flint, MI 48532
810.342.2384

ND.MF.101.4.18



MCLAREN'S COMMITMENT TO QUALITY CARE HELPS REBUILD LIVES ONE STEP AT A TIME

McLaren
FLINT
INPATIENT
REHABILITATION FACILITY

Welcome to McLaren Flint's Inpatient Rehabilitation Facility. Thank you for choosing us to take care of you during the next step in your recovery. We are privileged to be a part of your team. Our experienced and dedicated clinicians will work with you and your family to achieve your goals, providing quality and respectful care throughout your stay.

REHABILITATION PROGRAM

Rehabilitation is an active program. You will participate in a minimum of three hours of therapy five out of seven days each week. The days you don't have therapy will be for rest or visiting with friends and family.

Your rehabilitation team may include:

- Dietitian
- Internist (physician, manages your medical needs)
- Nursing (including rehabilitation nurse)
- Occupational therapist
- Other medical and surgical specialists
- Physiatrist (physician, directs your rehabilitation)
- Physical therapist
- Psychologist
- Recreation therapist
- Social worker
- Speech therapist

A TYPICAL DAY

Your room will have a communication board that will show your Rehab team and therapy schedule. Below is a sample of what a typical day may look like for you.

7:00 a.m.	Breakfast served in your room
7:45-8:30 a.m.	Practice morning routine (with occupational therapy or nursing)
8:30-11:45 a.m.	Therapy sessions
Noon	Lunch served in dining room
1-4 p.m.	Therapy sessions
4 p.m.	Activities in dining room or community
5 p.m.	Dinner served in dining room
6 p.m.	Evening activities in dining room

Family

We welcome and encourage your family to be a part of your rehabilitation process, especially those who will be assisting you once you return home. We consider family an important part of your recovery. We will provide education and training along the way; before discharge, we will ask your family to come in for training so we can ensure your safe return home.

WHAT TO BRING

Personal Items

- Glasses
- Contact lenses and supplies
- Hearing aids and batteries
- Dentures
- Comb or hairbrush, hair products, make-up, shaving gear
- Toiletries (we have basic hospital toiletries, but if you prefer your favorite brand of toothpaste, deodorant or an electric tooth brush, please bring those)
- Wristwatch

Clothing

- 4-5 sets of comfortable, loose-fitting clothes that are easy to get on
- T-shirts
- Sweatpants or elastic-waist pants
- Socks and underwear
- Pajamas and slippers
- Sweater or hoodie (button or zip-front preferred)
- Athletic shoes or comfortable walking shoes that tie or have Velcro fasteners
- Seasonal jacket or coat

Adaptive Equipment

If you are using any adaptive equipment at home, please feel free to bring that item and make certain that it is clearly labeled. Examples may include:

- Wheelchair (including cushion and leg rests)
- Walker or cane
- Leg or arm brace
- CPAP or BiPAP machine

Dx:

HX:

_____

Allergies:

Consults:

Home Med List Obtained: Y / N

Age:

(Patient sticker)

Code Status:

Activity: Precautions: Fall / Asp / Sz / Bleed

Equipment: WC / Walker / Cane / Lift / Slide Board / Other:

SCD's: Y / N Up / Down Schedule

Vaccines:

Flu	Pna
Recd	Recd
Refused	Refused
N/I	N/I

Bowel / Bladder Program:
q2h void
PVR / bladder scan

Dialysis: Y / N Days:
Access Site:

(Eliquis/Brilinta sticker)

DIET: Reg / 1800 / Cardiac / Dys I / Dys II / Dys III **DW**: Yes / M & Th a.m.

Liquids: Thin / Nectar / Honey FR: _____ ml/day

PEG: Y / N Tube Feed: Rate: Flush:

Updated Discharge Plan:

DATE:
RN: **0700-1900**

A/O x _____ GCS: _____
Neuro √: Qshift or _____

Hearing aid: ☐
Glasses:☐
Dentures: ☐

Lung Sounds:
O2: _____
CPAP / Bipap
Trach: (size & type): _____

Bowels: Cont / Incont
Last BM:

Ostomy:

FALL RISK SCORE: _____
Bed alarm: Y / N
Velcro Belt: Y / N
Chair alarm: Y / N
Alarm Belt: Y / N
Other: _____

Bladder: Cont / Incont
Foley: Y / N Date:
Indication:

Complete skin assessment done this shift: Y / N Turning Clock: Y / N
Wounds:
Incisions:
Dressings: Dsg △:

Vitals: (BP)_____(HR)_____(RR)_____(T)_____
Glucs: Y / N 0700 _____ 1200 _____ 1700 _____

IV SITES: _____ exp: _____ IVF: _____
IV Meds:

WBC: _____ Plt:_____ Hgb:_____ Hct:_____
PTT:_____ INR:_____ BNPEP:_____ Alb:_____
NA:_____ K:_____ Mg:_____ Phos:_____ Cal:_____
BUN:_____ CR:_____ CO2:_____ Chl:_____ Ion Cal:_____
TROP: _____ _____ _____ _____
Addl labs

Meds: 07 08 09 10 11 12 13 14 15 16 17 18 19

Other Tests/Notes:

DATE:
RN: **1900-0700**

A/O x _____ GCS: _____
Neuro √: Qshift or _____

Hearing aid: ☐
Glasses:☐
Dentures: ☐

Lung Sounds:
O2: _____
CPAP / Bipap
Trach: (size & type): _____

Bowels: Cont / Incont
Last BM:

Ostomy:

FALL RISK SCORE: _____
Bed alarm: Y / N
Velcro Belt: Y / N
Chair alarm: Y / N
Alarm Belt: Y / N
Other: _____

Bladder: Cont / Incont
Foley: Y / N Date:
Indication:

Complete skin assessment done this shift: Y / N Turning Clock: Y / N
Wounds:
Incisions:
Dressings: Dsg △:

Vitals: (BP)_____(HR)_____(RR)_____(T)_____
Glucs: Y / N 2100 _____ HS Snack given: Y / N

IV SITES: _____ exp: _____ IVF: _____
IV Meds:

WBC: _____ Plt:_____ Hgb:_____ Hct:_____
PTT:_____ INR:_____ BNPEP:_____ Alb:_____
NA:_____ K:_____ Mg:_____ Phos:_____ Cal:_____
BUN:_____ CR:_____ CO2:_____ Chl:_____ Ion Cal:_____
TROP: _____ _____ _____ _____
Addl labs

Meds: 20 21 22 23 00 01 02 03 04 05 06

Other Tests/Notes:

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 Braces/Splints		Dentures ___Upper ___Lower		Jewelry Keys		Purse Wallet **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

INPATIENT REHAB

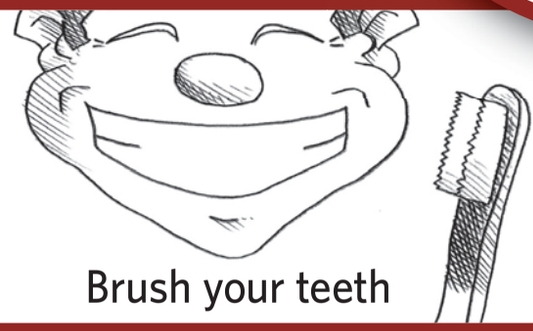
EXPECTATIONS

To get the most out of your Inpatient Rehab experience, and help prepare you to go home, here are some activities you should do every day:

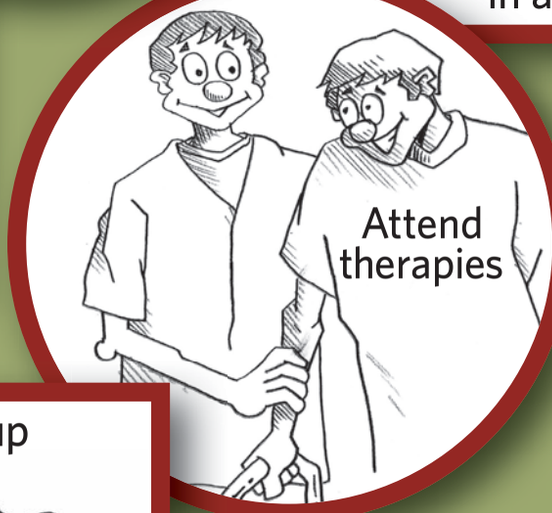
Use the toilet in the bathroom

Eat at dining table in a chair

Get dressed in your own clothes



Brush your teeth



Attend therapies

Brush your hair

Wash up

These activities will physically and mentally prepare you for home. Eating together in a group setting allows for socialization, exercising your thinking skills through conversation, encouraging one another, and encouraging increased food intake if at nutritional risk (as shown by studies).

M-2945A

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

PT.

MR.#/P.M.

DR.

McLaren
FLINT

FAMILY MEMBER FALL PREVENTION AGREEMENT

I, _____, make this pledge to keep my loved one from falling. I understand that if the patient were to fall, they could suffer serious injury that may prolong their hospital stay. This contract serves as an agreement between the healthcare providers and patient family to better protect the patient from injury related to a fall.

- **I WILL** ask for help when getting my loved one up
- **I WILL** encourage the patient to use the call light
- **I WILL** notify the nurse when I am leaving

- **I WILL NOT** turn off alarms
- **I WILL NOT** leave my loved one unattended in the bathroom

I agree to follow these instructions in knowing that my actions will help to keep those I care about **SAFE**! I agree to be an active participant in maintaining my loved one's safety by preventing injuries from falls. In signing this agreement I am agreeing to the above statements that will help prevent my loved one from falling.

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____

PT.

MR.#/P.M.

DR.

McLaren
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

PT.

MR.#/RM.

DR.

820b

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

LIVANTA

1-888-524-9900 or Medicare TTY 1-888-985-8775

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call **(810) 342-2375**

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative Signature _____ Date/Time: _____

☐ Unable to sign/Pt.Representative Notified Date/Time: _____

Certified Mail Number _____ - _____ - _____ - _____ - _____

Form CMS-R-193 (approved 07/10)

Original - Chart
2nd Copy - Patient
3rd Copy - Patient

Steps To Appeal Your Discharge

Step 1: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

- Here is the contact information for the QIO:

LIVANTA

1-888-524-9900 or Medicare TTY 1-888-985-8775

- You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
- Ask the hospital if you need help contacting the QIO.
- The name of this hospital is :

Hospital Name	Provider ID Number
McLaren Flint	**#23-0141**

Step 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

Step 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

Step 4: The QIO will review your medical records and other important information about your case.

Step 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.

- If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
- If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Additional Information:

☐ Subsequent Notice Date/Time: _____ Pt. Representative Initials _____

☐ Unable to sign/Pt.Representative Notified Date/Time: _____

Certified Mail Number _____ - _____ - _____ - _____ - _____

☐ Other: _____

McLAREN FLINT
FLINT, MICHIGAN

MEDICARE PATIENT RIGHTS REGARDING INPATIENT REHABILITATION SERVICES

As part of your inpatient rehabilitation stay, information will be gathered about you to develop a plan of care. The Medicare assessment will also help determine payment for your care. You have specific rights with regard to this assessment. They are as follows:

- The rights to be informed of the purpose of this patient assessment data collection.
- The right to have any patient assessment information remain confidential and secure.
- The right to be informed that the patient assessment information will not be disclosed to others except for legitimate purposes allowed by the Federal Privacy Act and Federal State regulations.
- The right to refuse to answer patient assessment data questions.
- The right to see review and request changes on the patient assessment instrument.

The above rights were reviewed and discussed with the patient in full. I received a copy of the two-page form entitled Privacy Act Statement - Health Care Records.

_____ _____

McLaren Employee Date

_____ _____

Patient Date

In addition, you may ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal identifying health information which this Federal agency maintains in its IRF-PAI System of Records. For CONTACT INFORMATION or a detailed description of your privacy rights, refer to the attached PRIVACY STATEMENT - HEALTH CARE RECORDS.
Note: The rights listed above are in concert with the rights listed in the hospital conditions of participation and the rights established under the Federal Privacy Rule.

NOTICE OF PRIVACY PRACTICES

Version effective: May 2018

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THE PRACTICES OUTLINED IN THIS NOTICE?

McLaren Health Care ("McLaren") provides health care to our patients in partnership with physicians, health care providers, and other professionals and organizations in an organized health care arrangement (hereinafter referred to as we, our or us). This is a joint Notice of our information privacy practices. The practices in this Notice will be followed by:

- Any health care professional who participates in an organized health care arrangement with us to assist in providing treatment to you. These professionals may include, but are not limited to, physicians, allied health professionals, and other licensed health care professionals;
- All subsidiaries and departments of our organization, except our health plans, including hospital, emergency department, outpatient services, mobile units, skilled nursing, clinics/hospital-owned physician practices, urgent care centers, home health, hospice, cancer centers, and retail outlets as well as those outside our system with whom we've contracted for assistance in providing services.
- Our employees, staff and volunteers, including corporate offices and affiliates.

A complete list of McLaren organizations covered by this Notice may be found on our Website; if you do not have a computer you may request a list by calling our Compliance Line.

OUR PLEDGE TO YOU

We understand that health information about you is private and personal, and we are committed to protecting it. Each time you visit a hospital, physician or other health care provider, a record of your visit is made. This Notice applies to the records of your care at McLaren, whether created by facility staff or your personal physician. Other health care providers providing treatment to you may have different practices or Notices regarding their use and disclosure of health information about you maintained in their own offices or clinics.

We are required by law to make sure that health information that identifies you is kept private, give you this Notice of our legal duties and privacy practices concerning your health information, and follow the terms of the Notice that is currently in effect.

CHANGES TO THIS NOTICE

We may change our practices from time to time. Changes will apply to health information we already hold, as well as new information after the change occurs. If we make a significant change in our practices, we will change our Notice and post the new Notice in prominent locations in our facilities and on our Website at: www.mclaren.org/privacy.

NOTICE OF PRIVACY PRACTICES

Version effective: May 2018

OUR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Your health information, linked with your name or other identifying information is used in many ways such as providing care, obtaining payment for your care and running our business. Disclosures of your health information for purposes described in this Notice may be made in writing, orally, electronically, or by facsimile. As permitted by HIPAA and Michigan State law, we may use or disclose your health information for several purposes. Here are some examples of how we may use or disclose your health information.

Treatment: We may use your health information to provide you with medical care in our facilities or in your home. We also may share your health information with others who provide care to you, such as hospitals, nursing homes, doctors, nurses, physician assistants, medical and nursing students, therapists, technicians, emergency service and transportation providers, medical equipment providers, pharmacies, and others involved in your care. For example, different hospital departments may share your health information to coordinate your prescriptions, laboratory, x-rays and other medical needs.

Payment: We may use and disclose your health information as needed to get paid for the medical care that we provide to you or to assist others who care for you to get paid for that care. For example, we may share your health information with a billing company or with your health insurance plan to obtain prior approval for your care or to make sure your plan will cover your care.

Health Care Operations: We may use or disclose your health information for our quality assurance activities and as needed to run our health care facilities. We may use your health information in combination with other patients' health information to compare our efforts and to learn where we can improve our care and services. We also may use or disclose your health information to get legal, auditing, accounting and other services and for teaching, business management and planning purposes. We may disclose your information to businesses and individuals (e.g., medical transcription service) who perform services for us involving health information as long as they agree to protect the privacy of that information.

Health Information Exchange (HIE): We participate in Health Information Exchanges such as Great Lakes Health Connect and CommonWell. As permitted by law, your health information is electronically shared with HIEs for the purpose of improving the overall quality of health care services provided to you (e.g., by avoiding unnecessary duplicate testing). Health Information Exchanges are required to maintain appropriate administrative, technical and physical safeguards to protect the privacy and security of your protected health information. Only authorized individuals may access the HIE and use your protected health information. You have the right to request in writing that we not disclose any of your protected health information to the HIE. Except for health information required by law to be shared with the HIE, you may 'opt-out' or restrict the sharing of your health information by contacting the Information Privacy Office listed at the end of this notice. Opting out may result in a health care provider not having access to information necessary for the provider to render appropriate care to you.

Media Condition Reports: We may release your health information for an update to the media if the media requests information about you using your full name. The following information may be disclosed: your condition described in general terms such as "good", "fair", "serious", or "critical". You have the right to request that this information not be released.

Appointments Reminders: We may use your health information to contact you about upcoming appointments. These reminders may be communicated by using the following methods: text message, email, mail and telephone.

NOTICE OF PRIVACY PRACTICES

Version effective: May 2018

On-Site Contacts: While in our facilities, we may need to contact you by overhead page or ask you to write your name on a sign-in sheet. In these instances, we take reasonable precautions to protect your privacy.

Individuals Involved in Your Care or Payment for Care: We may share health information about you with a friend or family member who is involved in your medical care, with others whom you designate as involved in your medical care or with disaster relief authorities so that your family can be notified of your location and condition.

Patient Directory: We may include certain limited information about you in the patient directory while you are a patient at any of our hospitals. This information may include your name, location in the hospital, your general condition as well as your religious affiliation and may also be released to people who ask for you by name. You have the right to opt out of being listed in our patient and/or religious directory.

Treatment Alternatives, Health Benefits, and Services: We may use and disclose your health information to tell you about treatment alternatives, and health-related benefits and services. We may use your information to tell you about our products or services or to provide gifts of nominal value to you or your family.

Fundraising Activities: We may use certain information, including, but not limited to, name, address, and phone number, to contact you to raise money for a McLaren hospital. The money raised will be used to expand and improve the services and programs we provide to the community. You have the right to opt out of fundraising communications.

Research: Under certain circumstances, we may use or disclose health information about you, for research purposes, without your authorization. However, the information would be limited to health information needed in preparation for conducting research (e.g., to help look through records with specific medical conditions to aide in finding a cure). Research projects must be cleared through a special approval process before any health information is disclosed to the researchers and the researchers will be required to protect the health information they receive.

Releases Required by Law: We may use health information about you without your prior permission for several other reasons. Subject to applicable law, we may give out health information about you to other persons or entities to carry out their duties for (a) public health purposes (such as, births, deaths, public health surveillance); (b) abuse, neglect or domestic violence reporting; (c) health oversight audits or inspections; (d) coroners or medical examiner services; (e) funeral arrangements; (f) organ donation; (g) tracking of FDA-regulated products; (h) worker's compensation purposes; (i) emergencies, such as disaster relief efforts; (j) data de-identification; and (k) data aggregation. We also share health information with others when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative order. We may share immunization records with schools if required by state law, and if you or a parent, guardian or other individual acting in the place of a parent agrees.

Releases Requiring Your Permission: We will not use or disclose your health information without your written authorization, except as listed above. Except in limited circumstances, use or disclosure of psychotherapy notes, or use and disclosure of health information for marketing purposes, or the sale of health information require specific written permission. If you give us written permission, you can cancel that permission, except for uses and disclosures already made based on your permission.

NOTICE OF PRIVACY PRACTICES

Version effective: May 2018

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Access and Copies: In most cases, you have the right to look at or get a copy of health information that we use to make decisions about your care. If you request copies of the information, however, we may charge a fee for cost of copying, mailing or other related supplies. If we deny your request to look at the information or get a copy of it, you may give us a written request for a review of that decision. In some instances your health information may not be available due to our retention policy.

Correct or Update: If you believe that information in our records about you is incorrect or if important information is missing, you have the right to request that we change the records, by submitting a request in writing and including your reason for requesting the change. We may deny your request to change a record if the information was not created by us; if it is not part of the health information kept by us; or if we determine the record is complete and correct. If we deny your request to change, you may submit a written request to review that denial.

List of Disclosures: You have the right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations, or information provided directly to you or your family, or information that was disclosed with your authorization.

Confidentiality: You have the right to request that health information about you be shared with you in a confidential manner, such as sending mail to an address other than your home.

Notification of a Breach: If our actions result in a breach of your unsecured health information we will notify you of that breach.

Restrict Disclosures to Your Health Plan: You may request that we not share health information with your health plan about care or services you received, **if you pay in full out of pocket for those services and make the request in writing at the time the services are provided**.

Copies of Our Notice of Privacy Practices: You may ask for a copy of our current Notice at any time. If the Notice was sent to you electronically, you may request a paper copy.

Complaints: If you have any questions about this Notice of Privacy Practices, or questions or complaints about the handling of your health information, you may contact the Information Privacy Office, in writing or call or submit a report to our Compliance Line. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

Who to Contact: To exercise any of the rights described above, please send a written request to our Information Privacy Office at the address listed below, or download and complete the Privacy Request form located on www.mclaren.org/privacy. If you do not have access to a computer, then you may call our Compliance Line and request a form be mailed to you. Completed forms may be mailed to our address below, emailed to privacy@mclaren.org or faxed to 810-342-1450.

McLaren Health Care
Information Privacy Office
One McLaren Parkway
Grand Blanc, MI 48439
Compliance Line: 1-866-642-2667

McLaren
FLINT

Your New Medication Use and Side Effect Information

The purpose of this document is to provide you with some information about why you are taking a medication. This document will also explain the possible medication side effects of the medication you are taking. If you have any questions or concerns about this information listed below, please ask to speak with your nurse or pharmacist.

What is my Medication? Medication: Generic (Brand)	Why am I taking it? This medication is for:	What are the Possible Side Effects:
Narcotics: ☐ Hydrocodone/Acetaminophen (Norco, Lortab) ☐ Hydromorphone (Dilaudid) ☐ Fentanyl ☐ Morphine ☐ Oxycodone/Acetaminophen (Percocet) ☐ Oxycodone ☐ _____	**Pain** 	Dizziness Drowsiness (feeling tired) Itching Constipation Nausea/Stomach upset Slow/Difficulty Breathing
Antiemetics: ☐ Metoclopramide (Reglan) ☐ Ondansetron (Zofran) ☐ Prochlorperazine (Compazine) ☐ Promethazine (Phenergan) ☐ _____	**Nausea or Vomiting** 	Headache Weakness Dizziness Drowsiness Constipation Restlessness
Acid Reducers: ☐ Pantoprazole (Protonix) ☐ Famotidine (Pepcid) ☐ _____	**Heartburn or Reflux** 	Headache Diarrhea Abdominal pain Dizziness (Pepcid) Constipation (Pepcid)
Statins: ☐ Atorvastatin (Lipitor) ☐ Pravastatin (Pravachol) ☐ Simvastatin (Zocor) ☐ _____	**Decreasing Cholesterol** 	Headache Nausea Diarrhea Muscle pain or weakness ➢ Call Medical Provider
Non-Steroidal Anti-inflammatory Drugs (NSAIDS) ☐ Diclofenac (Voltaren) ☐ Ibuprofen (Advil, Motrin) ☐ Ketorolac (Toradol) ☐ Naproxen (Aleve) ☐ _____	**Help to decrease pain and /or Help to reduce inflammation** 	Bleeding risk GI symptoms Dizziness Headache
Antiplatelets: ☐ Aspirin (Ecotrin, Bayer) ☐ Clopidogrel (Plavix) ☐ Prasugrel (Effient) ☐ Ticagrelor (Brilinta) ☐ _____	**Prevent Blood Clots** 	Risk of Bleeding GI Upset Headache Difficulty breathing (Brilinta)

Medication: Generic (Brand)	Medication Used For:	Possible Side Effects:
Anticoagulants: ☐ Warfarin (Coumadin) ☐ Enoxaparin (Lovenox) ☐ Heparin ☐ Apixaban (Eliquis) ☐ Dabigatran (Pradaxa) ☐ Rivaroxaban (Xarelto) ☐ _____	**Preventing or Treating Blood Clots** 	Risk for Bleeding Bruising Abdominal pain (Warfarin) Fever (Enoxaparin) Nausea (Enoxaparin)
Antiarrhythmics: ☐ Amiodarone (Cordarone, Pacerone) ☐ Digoxin (Lanoxin) ☐ Flecainide (Tambocor) ☐ Propafenone (Rythmol) ☐ Sotalol (Betapace) ☐ _____	**Abnormal Heart Rhythm; Heart Failure** 	Dizziness Headache Nausea/vomiting Difficulty breathing Tiredness
Calcium Channel Blockers: ☐ Diltiazem (Cardizem, Tiazac, Dilacor XR) ☐ Verapamil (Calan, Verelan) ☐ Amlodipine ☐ _____	**Decreasing Blood Pressure and Heart Rate** 	Dizziness Headache Constipation (Verapamil)
Beta Blockers: ☐ Atenolol (Tenormin) ☐ Carvedilol (Coreg) ☐ Metoprolol (Toprol XL, Lopressor) ☐ _____	**Heart Failure; Decreasing Blood Pressure and Heart Rate** 	Dizziness Drowsiness Fatigue
ACE Inhibitors or ARBs: ☐ Lisinopril (Zestril, Prinivil) ☐ Valsartan (Diovan) ☐ Entresto (CHF) ☐ _____	**Decreasing Blood Pressure; Heart Failure** 	Dizziness Dry cough Headache
Corticosteroids: ☐ Methylprednisolone (Solumedrol) ☐ Dexamethasone (Decadron) ☐ Prednisone (Deltasone) ☐ _____	**Decreasing Inflammation** 	GI upset Increased appetite Increased blood sugar
Antibiotics: ☐ Amoxicillin (Amoxil) ☐ Cefazolin (Ancef, Kefzol) ☐ Clindamycin ☐ Levofloxacin ☐ Piperacillin/Tazobactam (Zosyn) ☐ Vancomycin (Vancocin) ☐ _____	**Treating Bacterial Infection** 	GI upset Rash Itching Diarrhea Headache

Miscellaneous Medications: _____

BRIEF INTERVIEW OF MENTAL STATUS (BIMS)

HEARING, SPEECH & VISION

Expression of ideas and wants *(Circle Appropriate Answer)*

(consider both verbal & non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** & with speech that is clear & easy to understand
3. Exhibits **some difficulty** with expressing needs & ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

Understanding Verbal Content

(with hearing aid or device, if used and excluding language barriers)

4. **Understands**: Clear comprehension without cues or repetitions
3. **Usually Understands**: Understands most conversations, but misses some parts/intent of message. Requires cues at times to understand
2. **Sometimes understands**: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/ Never Understands**

COGNITIVE PATTERNS

Repetition of Three Words

Ask Patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **Sock, Blue and Bed**. Now tell me the three words."

Number of words repeated by patient after first attempt:

3. Three
2. Two
1. One
0. None

After the patient's first attempt say: "I will repeat each of the three words with a cue and ask you about them later: Sock, something to wear; blue, a color; bed, a piece of furniture." (You may repeat the words up to two more times.)

Temporal Orientation: Year, Month, Day

Ask patient:	**Ask patient**:	**Ask patient**:
"Please tell me what year it is right now."	"What month are we in right now?"	"What day of the week is today?"
Patient's answer is:	*Patient's answer is:*	*Patient's answer is:*
3. Correct	2. Accurate within 5 days	1. Correct
2. Missed by 1 year	1. Missed by 6 days to 1 month	0. Incorrect or no answer
1. Missed by 2-5 years	0. Missed by more than 1 month or no answer	
0. Missed by more than 5 years or no answer		

Recall

Ask patient: "Let's go back to the first question. What were those three words that I asked you to repeat?"

If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.

Recalls "sock?"	**Recalls** "blue?"	**Recalls** "bed?"
2. Yes, no cue required	2. Yes, no cue required	2. Yes, no cue required
1. Yes, after cueing ("something to wear")	1. Yes, after cueing ("a color")	1. Yes, after cueing ("a piece of furniture")
0. No, could not recall	0. No, could not recall	0. No, could not recall

Memory/Recall Ability

Check all that the patient was normally able to recall

☐ Current season
☐ Location of own room
☐ Staff names and faces
☐ That he or she is in a hospital/hospital unit
☐ None of the above were recalled

Clinician Signature: **Date/Time:**

PT.

MR.#/P

DR.

McLaren Flint
FLINT, MI

Unit Clerk Discharge Checklist Worksheet

Tabs in order of Break Down	**Present Yes**	**Not Applicable**
Facesheet		
****Discharge Instructions****		
1. Patient Discharge Instructions		
2. Patient Discharge Medication List		
(Copy of form given to patient with boxes checked and signatures)		
Notified discharge nurse _____ if missing _____ (initials)		
****Discharge Instructions FOR Nursing Home****		
1. Discharge by Transfer Form		
Notified discharge nurse _____ if missing _____ (initials)		
****Instructions FOR Hospital-to-Hospital transfers****		
1. Transfer Consent Form		
Notified discharge nurse _____ if missing _____ (initials)		
Legal documents		
Physician Orders		
Progress Notes		
H&P		
EKG		
Echo (Required for Heart Failure, AMI patients) **[CORE MEASURE REQUIREMENT]**		
OR		
Consults		
Miscellaneous (any other documents)		
Patient Belongings Inventory Form - Signed Off		

****Elements that require sign-off by Medical Records & Nursing Unit Personnel before chart leaves the unit.**

Unit _____ Unit Clerk Signature _____ Date/Time _____

Manager / ANM Signature _____ Date/Time _____

Medical Records		
Nurse Manager Notified/Chart Elements Missing: ☐ Discharge missing ☐ Discharge not completed ☐ Checklist not complete/signed	Signature:	Date/Time:

THIS FORM AFTER DISCHARGE
IS A PERMANENT PART OF
THE MEDICAL RECORD

PT.

MR.#/RM.

McLAREN HEALTH CARE

OPIOID START TALKING

(MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD)

Patient Name:	Date of Birth:
Name of Controlled Substance containing an Opioid:	
Dosage	Quantity Prescribed (For a minor, if signature is not the parent or guardian, the prescriber must limit the opioid to a single, 72 hour supply)
Number of Refills: ☐ MAPS check, date:_____	☐ Acute pain < 3 days (No MAPS) ☐ Acute pain 4-7 days ☐ Chronic pain > 7 days

A controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse. My provider shared the following:

a. The risks of substance use disorder and overdose associated with the controlled substance containing an opioid.

b. Individuals with mental illness and substance use disorders may have an increased risk of addiction to a controlled substance. (Required only for minors.)

c. Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drug that may depress the central nervous system can cause serious health risks, including death or disability. (Required only for minors.)

d. For a female who is pregnant or is of reproductive age, the heightened risk of short and long-term effects of opioids, including but not limited to neonatal abstinence syndrome.

e. Any other information necessary for patients to use the drug safely and effectively as found in the patient counseling information section of the labeling for the controlled substance.

f. Safe disposal of opioids has shown to reduce injury and death in family members. Proper disposal of expired, unused or unwanted controlled substances may be done through community take-back programs, local pharmacies, or local law enforcement agencies. Information on where to return your prescription drugs can be found at http://www.michigan.gov/deqdrugdisposal.

g. It is a felony to illegally deliver, distribute or share a controlled substance without a prescription properly issued by a licensed health care provider.

I acknowledge the potential benefits and risks of an opioid medication as described by my provider along with the responsibility of properly managing my medication as stated above.

Signature of Prescriber (when prescribing to a minor)	Date
Signature of Patient, if a minor, patient's parent/guardian	Date
Signature of Patient's Representative or other authorized adult	Date
Printed Name of Parent/Guardian; Patient's Representative or authorized adult	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	AUTHORITY: PCA 246 of 2017, MCL 333.7303b and MCL 333.7303c COMPLETION: Required. PENALTY: Probation, limitation, denial, fine, suspension, revocation or permanent revocation

White Copy: Medical Records
Yellow Copy: Patient

PT.

MR.#/P

DR.

McLAREN FLINT
FLINT, MICHIGAN 48532

PROGRESS RECORD
EACH ENTRY MUST INCLUDE DATE, TIME AND SIGNATURE

DATE	NOTATIONS	SIGNATURE

PT.

MR.#/RM.

DR.

McLAREN FLINT
FLINT, MICHIGAN 48532

PROGRESS RECORD
EACH ENTRY MUST INCLUDE DATE, TIME AND SIGNATURE

DATE	NOTATIONS	SIGNATURE

PT.

MR.#/RM.

DR.

McLaren
FLINT

INPATIENT REHABILITATION
MANDATORY QUALITY INDICATOR FLOWSHEET

Date: _____ / _____ / _____

AMOUNT OF ASSISTANCE:

Percentage of **staff** assistance -

0% *(No assistance needed)* 25% 50% 75% 100%

Not attempted due to:

Patient Refused - R **Medical Condition - M**

Not Applicable - NA **Safety Concerns - S**

EATING	**Night**	**Day**	**Eve**
Requires dentures to eat	Y N	Y N	Y N
Needs tray supervision / set-up	Y N	Y N	Y N
Eats regular consistency diet	Y N	Y N	Y N
Amount of assistance to eat	% of Assist.	% of Assist.	% of Assist.
% eaten	%	%	%
GROOMING			
Needs supervision / set-up	Y N	Y N	Y N
Amt. of assistance w/grooming	% of Assist.	% of Assist.	% of Assist.
Amt. of assistance w/oral hygiene	% of Assist.	% of Assist.	% of Assist.
BATHING			
Needs supervision / set-up	Y N	Y N	Y N
Amount of assistance	% of Assist.	% of Assist.	% of Assist.
DRESSING & UNDRESSING			
Needs supervision / set-up	Y N	Y N	Y N
Amt. of assistance w/ upper body dressing	% of Assist.	% of Assist.	% of Assist.
Amt. of assistance w/lower body dressing, including footwear	% of Assist.	% of Assist.	% of Assist.
Amt. of assistance with socks/shoes	% of Assist.	% of Assist.	% of Assist.
TOILETING			
Asst. w/ perineal hygiene	Y N	Y N	Y N
Asst. to pull pants down	Y N	Y N	Y N
Asst. to pull pants up	Y N	Y N	Y N

FYI - Bowel or bladder accident means soiling of clothes or bed linen.

BLADDER ASSISTANCE	**Night**	**Day**	**Eve**
# of wet linens, clothes or bedpan/urinal spills			
Equipment used: bedpan (bp), brief (b), commode(c), condom cath (cc), foley cath (f), medication (rx), ostomy (o), pantiliner (p), straight cath (sc), toilet (t), urinal (u)			
Does pt empty cath / bedpan / urinal by self	Y N	Y N	Y N
Amt. of assistance with equipment	% of Assist.	% of Assist.	% of Assist.
BOWEL ASSISTANCE			
# of soiled linens, clothes or bedpan spills			
Equipment used: bedpan(bp), brief(b), bedside commode (bsc), medication (rx), toilet (t)			
Amt. of assistance with equipment	% of Assist.	% of Assist.	% of Assist.
BED TRANSFERS			
Amount of Assistance	% of Assist.	% of Assist.	% of Assist.
# of helpers	0 1 2	0 1 2	0 1 2
TOILET TRANSFERS			
Asst. to toilet/commode	% of Assist.	% of Assist.	% of Assist.
# of helpers	0 1 2	0 1 2	0 1 2
Uses raised toilet seat (rt), commode (c), grab bars (gb), slide board (sb), gait belt (g)			
SHOWER TRANSFERS			
Amount of Assistance	% of Assist.	% of Assist.	% of Assist.
# of helpers	0 1 2	0 1 2	0 1 2

COMMENTS: _____

_____

_____

NURSING/ASSISTANT SIGNATURES:

Night _____

Day _____

Eve _____

PT.

MR.#/RM.

DR.

MANDATORY QUALITY INDICATOR FLOWSHEET

17537 Rev. 9.16

700

McLAREN FLINT
Flint, Michigan

PHYSICAL MEDICINE AND REHABILITATION DISCHARGE SUMMARY

Date Admitted to Rehab: _____ / _____ / _____ ICG Code: _____

Date Discharged from Rehab: _____ Etiological Diagnosis: _____

Case Coordinator: _____

F/U Plan of Care: _____

Discharge Destination: _____

Signature: _____ Date: _____ / _____ / _____

NSG: _____

Signature _____ Date: _____ / _____ / _____

480

PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan
PHYSICAL MEDICINE AND REHABILITATION DISCHARGE SUMMARY

ST: _____

Signature: _____ Date: _____ / _____ / _____ Time: _____

TR: _____

Signature _____ Date: _____ / _____ / _____ Time: _____

PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan
PHYSICAL MEDICINE AND REHABILITATION DISCHARGE SUMMARY

PT: _____

_____

_____

ADMISSION

PHYSICAL THERAPY

Roll: supine L/R: _____

Sit>supine: _____

Supine>sit: _____

Sit<>Stand: _____

Chair<>bed: _____

Car Transfer: _____ Goal: _____

Ambulation: _____

Able to walk:

10 ft: Y/N Amt. of assist. needed: _____

10 ft on uneven surface: Y/N Amt. of assist needed: _____

50 ft with 2 turns: Y/N Amt. of asssist needed: _____

150 ft: Y/N Amt of assist needed: _____

Stairs:

Amt. of assist to go up 1 step (curb): _____

4 steps: _____ 12 steps: _____ Rails: _____

Balance: _____

Amt. of PA to pick object up from floor while standing: _____

W/C Mobility: _____

Able to wheel 50 ft. w/2 turns: Y/N Amt. of assist: _____

150 ft: Y/N Amt. of assist: _____

DISCHARGE

PHYSICAL THERAPY

Roll: supine L/R: _____

Sit>supine: _____

Supine>sit: _____

Sit<>Stand: _____

Chair<>bed: _____

Car Transfer: _____

Ambulation: _____

Able to walk:

10 ft: Y/N Amt. of assist. needed: _____

10 ft on uneven surface: Y/N Amt. of assist needed: _____

50 ft with 2 turns: Y/N Amt. of asssist needed: _____

150 ft: Y/N Amt of assist needed: _____

Stairs:

Amt. of assist to go up 1 step (curb): _____

4 steps: _____ 12 steps: _____ Rails: _____

Balance: _____

Amt. of PA to pick object up from floor while standing: _____

W/C Mobility: _____

Able to wheel 50 ft. w/2 turns: Y/N Amt. of assist: _____

150 ft: Y/N Amt. of assist: _____

_____

_____

_____

_____

_____

_____

Signature _____ Date: _____ / _____ / _____ Time: _____

PT.

MR.#/P.M.

DR.

McLAREN FLINT
Flint, Michigan
PHYSICAL MEDICINE AND REHABILITATION DISCHARGE SUMMARY

OT: _____

_____

_____

_____

_____

	INITITIAL	DISCHARGE	GOAL
Grooming			
Oral Hygiene			
Bathing			
UB Dressing			
LB Dressing			
Footwear On/Off			
Tub/Shower Transfer			
Toilet Transfer			
Toileting			
Dentures Yes/No			

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____ / _____ / _____

_____

_____

_____

_____

_____

I have reviewed, participated in, and agree with the discharge summaries represented in pages one through four of this document.

Signature (Dr. M. Margaret Snow, MD, Physiatrist):

_____

Date: _____ / _____ / _____ Time: _____

PT.

MR.#/P.M.

DR.