GOOD SHEPHERD MEDICAL CENTER MARSHALL

PT NAME:

HOSPITAL BED REQUEST / MARSHALL ORTHOPAEDICS [fax to 903-927-5712]

DIAGNOSIS:

DATE / TIME:

REASON FOR ADMISSION:

SYMPTOMS:

DRAINING WOUND?: COMMUNICABLE ?:

TYPE OF BED: UNIT/FLOOR REQUESTED: IPS

AIRBORNE INFECTION ISOLATION?: NO DROPLET PRECAUTIONS?: NO

CONTACT ISOLATION?: NO

ADMITTING PHYSICIAN: (ORDERS ATTACHED)

ADMIT TO CASE MANAGEMENT PROTOCOL

ADMIT TO :

_____

DATE / TIME

Case Manager Signature: _____ Date/Time: _____

Case management only – please do not write below this line

- ❑ Change from Observation to Inpatient Acute Care
- ❑ Change from Extended Recovery to Observation
- ❑ Change from Outpatient to a Bed in Observation
- ❑ Change from Inpatient to Outpatient Status [OPV]
- ❑ Change from Observation to OP Day Surgery
- ❑ Change from Inpatient to OP Day Surgery
- ❑ Change from Observation to Outpatient [OPV]
- ❑ Change from OP Day Surgery to Observation
- ❑ Outpatient in Bed
- ❑ Change from Inpatient Acute Care to Observation
  [patient condition does not meet inpatient severity of illness/intensity of service criteria per UM physician review]
- ❑ Medicare Condition 44

_____ _____

DATE / TIME

Case Manager Signature: _____ Date/Time: _____

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