The Reutlinger Community

Consent to Medical Treatment

I, _____ am a patient of the Reutlinger Community SNF Facility and I consent to the medical treatment rendered to me at RCJL as prescribed by my attending physician.

In case I need emergency medical treatment or care, I give consent to allow RCJL to have any medical doctor render such emergency treatment or care.

I authorize the purchase of medications and supplies, both routine and emergency, which will be needed by me through Pharmacy Pharmerica.

If this pharmacy is closed or otherwise unable to supply the medications needed, then a secondary supplier may be used. Drugs and medications as ordered by the physician will be billed to us directly by the pharmacy.

I understand I will pay all pharmacy charges, if not appropriately covered by a governmental program or private insurance plan. If I qualify for these programs, which include medication coverage, such coverage will be handled pursuant to the laws, rules and regulations of these programs.

Resident _____ Date_____

Responsible Party _____ Date_____

The Reutlinger Community

Co-Insurance Billing Process

Attachment G

The Reutlinger Community will bill your secondary insurance as a courtesy. Should the insurance be denied for any reason, the patient or family will be responsible for **100% of the payment**.

Secondary Insurance Name: _____

Policy Number: _____

Responsible Party Signature _____
Date: _____

Reutlinger Representative Signature _____
Date: _____

The Reutlinger Community

Bed Hold Informed Consent Form

Attachment I

Facility Name: The Reutlinger Community **Admit Date:** _____

It is the policy of this facility to provide residents the right to secure a bed during hospitalization of therapeutic leave from the facility as outlined in the Admission Agreement.

You have the option of requesting a seven (7) day bed hold to keep a bed vacant and available for return to this facility. Non Medi-Cal residents are responsible for the daily room costs, while Medi-Cal will cover the costs for a Medi-Cal resident. If you desire this option, you must notify this facility within 24 hours of transfer.

By signing this form, I acknowledge I have the right to exercise a bed hold.

Date: _____
Patient Name: _____

Signature of Patient/Responsible Party: _____

Facility Representative: _____

++

Second Notice of Bed Hold

You are being notified of your right to request a bed hold as described above and in the Admission Agreement.

Resident Name: _____ **Medical Record #:** _____

Date of Transfer: _____

Resident/Legal Representative notified by: _____

Name of Person Notified: _____

Notification Made In Person: _____ **Notification Made by Phone:** _____

The Reutlinger Community

Laundry Consent Form

Attachment J

( ) I Give Consent to Have the Facility Do the Laundry.

- **I understand that the facility will mark all laundry items with patient's name.**
- **I understand that all items must be checked in at the nursing station to be logged in on the inventory list.**
- **I will not bring any garments that need to be dry-cleaned because the facility does not provide these services.**
- **I agree that the facility will not be responsible for lost, stolen, or missing items that are not logged in on the inventory list.**

( ) I Do Not Give Consent to Have the Facility Do the Laundry and agree to the following:

- **I must supply a covered laundry container.**
- **I must pick up soiled laundry every other day.**
- **I understand that if laundry is excessively soiled, items may be washed by the facility to promote infection control.**
- **I will not bring in any garments that need to be dry-cleaned.**
- **I understand that all items must be checked in at the nursing station to be logged in on the inventory list.**
- **I agree that the facility will not be responsible for lost, stolen or missing items that are not logged in on the inventory.**

_____ _____

Signature of Resident/Responsible Party **Date:**

Resident Name: _____

Room Number:_____

The Reutlinger Community

Phone Service Selection

Attachment K

All patient room phones allow you to place and receive calls from your room or call another patient's room. Your phone will take messages for you when you are not there.

Each patient will have a direct phone number to be able to be reached when you are the Skilled Nursing Facility. There will be a $2.00 per month charge for all local long distance calls. Our long distance carrier is AT&T. You will be charged additionally for anything outside the area.

Phones can be restricted to limit a calling area. We highly recommend that you place an appropriate restriction on the phone based upon anticipated usage.

Please check one or all of the following restrictions:

No Restrictions (May Place International Calls) _____
North America Numbering Plan (No Calls outside of Continental U.S. _____
All California (No Calls Outside Of California) _____
Local Calls Only _____
No Outgoing Calls _____

Patient Name: _____

Room Number: _____

Admission Date: _____

Patient Signature: _____

Responsible Party Signature: _____

Date: _____

The Reutlinger Community

Resident Immunization & TB Record/Test

Attachment N-1

All Patients being admitted to the facility need to receive the pneumococcal and TD vaccines. If there is no vaccination record and/or admitting physician is uncertain, consider the resident as unvaccinated.

Pneumococcal Vaccine: Month/Year _____

Tetanus-Diphteria (TD) toxoid during last 10 years? Yes ☐ No ☐ **Date:** _____

Hospital, Doctor's Office, Other Facility to confirm _____

PPD Test

I/my family member gives consent to receive a PPD* test as part of the admission process for TB screening. Yes ☐ No ☐ **Date:** _____

I wish/do not wish to receive the following immunization(s)

	YES	NO	REASON
Pneumococcal Vaccine:	☐	☐	_____
Tetanus-diphtheria Toxoid	☐	☐	_____

Admission during the months of October through March

Influenza/Flu Vaccine: ☐ ☐ Date: _____

Facility: _____

I have been informed of the risks and benefits of receiving and/or not receiving the vaccine(s). I understand the potential risks and believe the benefits outweigh these risks.

_____ _____

Signature of Patient: **Date:**

_____ _____

Signature of Responsible Party: **Date:**

All individuals will receive the PPD* test (per facilities policy) as part of the admission for TB screening. *PPD is a skin test for T.B. and is required by law for all residents. The facilities policy on PPD is 2 steps, which means the PPD will be given again 14 days after the first PPD in order to assure accuracy.*

For further information on these tests, please see the facilities Business Office Manager or Social Services Designee.

Name	*Physician*	*MR#*

The Reutlinger – Guest Meal Policy

The Reutlinger Community
Assisted Living, Skilled Nursing and Rehabilitation

We encourage you to enjoy meals with your loved one during their stay at The Reutlinger. Please purchase a guest meal ticket from the concierge at a cost of $15 and provide your meal ticket to your server as your proof of purchase. If you do not purchase a meal ticket from the concierge you will be billed at a later date. Your signature authorizes that you understand and agree to our guest meal policy.

Name: _____

Signature: _____ Date: _____

Created: June 30th 2017

The Reutlinger Community

Acknowledgment of Advance Directive and POLST Form

Attachment H-1

I have been provided with information regarding my right to formulate an Advance Directive by the Admission Coordinator and/or nursing staff at The Reutlinger Community.

I DO possess an Advance Directive _____

Copy provided by: _____

Have Advance Directive but do not have copy to provide at this time: _____

I **DO NOT** possess an Advance Directive: _____

I **do wish** to formulate an Advance Directive: _____

I **do not** wish to formulate an Advance Directive: _____

I am **unsure** at this time if I want to formulate and Advance Directive: _____

POLST (Physician Orders for Life-Sustaining Treatment)

I have filled out a POLST and facility has it _____

I have not filled out a POLST and need to so _____

I do not wish to fill out a POLST at this time _____

_____ _____

Resident, Agent or Responsible Party Date

_____ _____

Facility Representative Date

*A copy of this signed acknowledgement must be provided to the Social Services Department.

The Reutlinger Community

Facility Mortuary Policy

Attachment H-2

To All Families and Responsible Parties

While we understand a family's hesitance to secure an arrangement with a mortuary at the time of admission, we believe it is important to take care of this as soon as possible. It is conceivable that you may not be within reach if the patient was to expire, or that the trauma is so great that you are not able to make a decision at that time. We feel it is best to make arrangements at the time of admission. The State requires that this information be a part of the chart. Families are expected to provide the facility, within 72 hours of admission, the name, address and phone number of the mortuary they have chosen.

Should the unexpected happen and the facility does not have the required information, the facility will be obliged to select a temporary mortuary. The Reutlinger Community has a contract with Sinai Memorial Chapel. The charge for this service levied by the mortuary are generally $200.00 per overnight stay. The charge will be passed on to the responsible party.

If there is any change of the mortuary of choice, you are expected to notify the facility in writing.

By signing this agreement you attest to your understanding of your obligation to provide The Reutlinger Community current information on mortuary arrangements and that you agree and will accept the charges if you do not comply.

I have read the above and agree to provide the facility with the information requested and understand and holding charges made by the mortuary should I not comply will be paid out of my personal account or by the responsible party.

Signature: _____ Date: _____

The Reutlinger Community

Mortuary Arrangement Form

Attachment H-3

It is the policy of The Reutlinger Community to ask that all applicants provide information regarding mortuary arrangements. You should have arrangements indicating a local mortuary to be contacted at the appropriate time. The form below lists the information that we require.
Please call Social Services at 925-964-2065 with any questions.

If you are interested in a mortuary that is familiar with Jewish customs, you may contact Sinai Memorial Chapel at 925-962-3636.

Patient Name: _____

Have you reserved a cemetery plot? _____ Is it paid for? _____

Who hold the deed? _____

Special wishes as to burial: _____

Name of mortuary to be contacted: _____

Address: _____
_____
_____

Family Contact: _____ Phone Number: _____

The Reutlinger Community

Salon Serenity Services

Attachment L

Service	Cost	Date Service Wanted
Shampoo Only	$5.00	_____
Shampoo & Set	$25.00	_____
Shampoo & Blow Dry	$25.00	_____
Hair Cut	$25.00	_____
Tint	$55.00	_____
Permanent Wave	$60.00	_____
Manicure	$15.00	_____
Pedicure	$25.00	_____
Waxing – Lip or Chin	$10.00	_____

Patient Name: _____

Room Number: _____

Payment Form: _____

Date Called: _____

Notes:

_____

_____

_____

_____

Salon Services Number: 925-964-2236
Barbara Compton or Vicky Flores