HEALTHCARE

PHYSICIAN ORDERS
ADMISSION / TRANSFER
INPATIENT, ED & ANCILLARY DEPARTMENTS

1. Fill in date and time.
2. Enter prescribed dose and prescribed interval for each medication.
3. Please print name, sign order and include pager number.
4. **Required information, designated by bold type, must be provided before medication can be dispensed or administered.**
5. Pediatric orders require dose / weight (mg / kg) format.

PATIENT ID LABEL

PRINT PATIENT NAME: _____

HEIGHT (inches): _____ **WEIGHT (kg):** _____ Initial to indicate if: _____ New Admission or _____ Transfer

Admit to Dr / Unit: _____ / _____ Transfer to Dr / Unit: _____ / _____

Demographic information in this section not required for patient transfers unless change has occurred since admission:

Diagnosis: _____ Condition: _____ Code Status: _____ Initial to indicate: **Pregnant:** ___ **Yes** ___ **No**

Breastfeeding: _____ **Yes** ___ **No** Vaccinations: Initial if current: _____ Influenza _____ Pneumococcal

Allergies and Reactions: _____

Comorbid Conditions (initial to indicate): ____ **Cardiac (ACS, CHF, AFIB)** ___ **Diabetes Mellitus** ___ **Renal** ____ **Hepatic** _____ **Respiratory**

Vital Signs: _____ Diet: _____ Activity: _____

Nursing / Respiratory Treatments: _____

Laboratory: _____

Diagnostic Tests with Justifying Signs / Symptoms: _____

PRESCRIBERS, PLEASE NOTE:

1. In order to comply with current medicare mandates, this patient will be evaluated for influenza and pneumococcal vaccine eligibility. If this patient meets the approved criteria vaccine will be administered unless you indicate otherwise. If you **DO NOT** wish for this patient to receive either of the mandated vaccines, please initial: **DO NOT ADMINISTER:** _____ influenza vaccine _____ pneumococcal vaccine
2. Automatic therapeutic interchange for specific medications, approved by the P&T committee, is permitted for all applicable medication orders unless the order contains special instructions stating "Do Not Interchange". The current approved therapeutic interchange list is available on the SAH Intranet Pharmacy homepage.

MEDICATION OR IV FLUID (no abbreviations)	DOSE / VOLUME	ROUTE	FREQ	INDICATION / SPECIAL INSTRUCTIONS
1) Copy or electronically provide all required patient information to Pharmacy with Admission Orders or first medication orders.				UNIT SECRETARY - copy completed Nursing Admission Assessment Form (page 1) *OR* NURSE - complete online PCS Nursing Admission Assessment, past medical history and Allergy screens

DATE	TIME	MD PRINT NAME	MD SIGNATURE		MD BEEPER / CONTACT #
ORDER TO PHARMACY		US / NURSE SIGNATURE	ORDER RECORDED	US SIGNATURE	NURSE SIGNATURE