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PHYSICIAN'S ORDER SHEET ADMISSION ORDERS

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT
AFTER EACH ORDER IS PROPERLY CHECKED, FAX ORDER SHEET
TO PHARMACY WHETHER OR NOT ORDERS INVOLVE MEDICATION.

Page 1 of 2

P A T I E N T I D E N T I F I C A T I O N	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy
			DIAGNOSIS:
			CODE STATUS:
			<input type="checkbox"/> FULL CODE: ADMINISTER CPR <input type="checkbox"/> DO NOT ATTEMPT RESUCITATION
			DIETARY: (Check Appropriate Orders)
			<input type="checkbox"/> REGULAR <input type="checkbox"/> MECHANICAL SOFT <input type="checkbox"/> PUREED
			<input type="checkbox"/> 2-4 GMS SODIUM <input type="checkbox"/> NO SALT ADDED
			<input type="checkbox"/> HOUSE CALORIE CONTROL (1200-1600 CAL.)
			<input type="checkbox"/> HOUSE DIABETIC (1700-2100 CAL.)
			<input type="checkbox"/> OTHER: _____
			<input type="checkbox"/> MAY LIFT DIETARY RESTRICTIONS AT FACILITY FUNCTIONS
			<input type="checkbox"/> TUBE FEEDINGS - INITIATE <u>TUBE FEEDING ORDER SHEET</u>
			THERAPY: EVALUATION REASON FOR EVALUATION:
			_____ PT <input type="checkbox"/> _____
			_____ OT <input type="checkbox"/> _____
			_____ SPEECH <input type="checkbox"/> _____
			CONSULTS:
			ACTIVITY LEVEL:
			<input type="checkbox"/> AD LIB <input type="checkbox"/> RESTRICTIONS <input type="checkbox"/> LOA WITH RESPONSIBLE PARTY
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____
			Nurse's Signature / Title _____

Military Time >>

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD

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PATIENT IDENTIFICATION

Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	DATE:	TIME:	(Military Time)
		LABWORK:		
		<input type="checkbox"/> ADMISSION LABWORK AND ANNUALLY PER POLICY #18:02		
		● CMP, CBC IF NOT DONE 1 WEEK PRIOR TO ADMISSION		
		● EKG IF NOT DONE WITHIN 1 MONTH OF ADMISSION		
		<input type="checkbox"/> ANNUAL LABS - CBC, CMP, TSH		
		<input type="checkbox"/> OTHER LAB ORDERS		
		MEDICATIONS / TREATMENTS	RATIONALE FOR USE	
		1. Flu vaccine 0.5 ml IM annually	Flu prevention	
		2. Pneumovax 0.5 ml IM now & in 5 yrs	Pneumonia prevention	
		3. PPD 0.1 ml intradermally on admission & annually. Repeat in 2 weeks, if negative.	TB Monitoring	
		4. Weekly weight times 4 wks		
		5.		
		6.		
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		17.		
		18.		
		19.		
		20.		
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____	
			Nurse's Signature / Title _____	

Military Time > >

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