Your Company Name
123 Company Lane - New York, NY 12345
Tel. (123) 456-7890 - Fax. (123) 456-7890

ADMIISSION/READMISSION PHYSICIANS ORDERS

NAME_______________________________________ RM# _____ SEX:______ DOB: ___/___/___ DO ADM:_________

TELEPHONE ORDER: MD________ YES [ ] NO [ ] READ BACK TO MD: YES [ ] NO [ ] NURSE ___________

MEDICATION / TREATMENT ORDERS	OTHER ORDERS
DX	Diet: _____________Regular ____________ Diabetic ___________ No Added Salt _________ No Concentrated Sweet___________ Reducing _________ Renal ________ Other ________________ Calories: __________ 1800_____ 1500_____Other ___________
DX	Consistency:_________Regular _________ Pureed __________ Chopped _______ Other __________________________ NPO _________________________________ _______ Tube Feeding = See separate tube feeding form.
DX	Activity Level: ___________________________ P.T Eval and Tx as indicated _______ O.T Eval and Tx as indicated _______ S.T Eval and Tx as indicated _______
DX	Permission to leave premises: _______Yes _______No Meds Required: _______Yes _______No Therapeutic Leave: _______Yes _______No Weights: ________ Monthly ________ Weekly ____________ Other
DX	DNR:________________ LABS: LFT'S / BMP / CBC PPD 0.1 ml intradermally. Read results 48 hours. Record induration in millimeters. If Negative_____0.1 ml Booster 7-14 days later.
DX	_______ Pneumovax 0.5ml IM _______ Flu Vac 0.5ml IM DENTAL Eval _________ PODIATRY Eval__________ OPTHALMIC Eval _________ PSYCHIATRIC Eval__________

DIAGNOSIS:

Physician Name:

[ ] Dispense As Written
This prescription will be filled generically unless prescriber writes 'DAW' in the box

Physician Signature: ______________________ Date: ______

Noted by: ______________________ Date: ______ Time: ______

Reviewed By: ______________________ Date: ______ Time: ______

Reviewed By: ______________________ Date: ______ Time: ______

ALLERGIES:

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