PHYSICIAN'S ORDER

MEDICATIONS	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR

NON-MEDICATION ORDERS

PAY TYPE

Facility: ____________________

Date of Admission: ____________________ [ ] Medicare A

[ ] Private [ ] Insurance Provider: ____________________ * Send copy of insurance cards, front and back.

[ ] Medicaid # ____________________ [ ] Medicare Part D Plan: ____________________

[ ] Medicare # ____________________ Social Security # ____________________

Responsible Party = Name: ____________________ Phone: ____________________

Street: ____________________ City: ____________________ State: ____________________ Zip: ____________________

MISCELLANEOUS

Sex: Male / Female (circle one)

Physician Name: ____________________ Alt. Physician: ____________________

Code Status: ____________________

LABORATORY

May Have Pneumovax Vaccine: [ ] Yes [ ] No LAB: ____________________ Every ____________________ Due: ____________________

May Have Annual Flu Vaccine: [ ] Yes [ ] No LAB: ____________________ Every ____________________ Due: ____________________

May Have Annual Mantoux: [ ] Yes [ ] No

SPECIALIZED SERVICES / THERAPY

[ ] P.T. [ ] O.T. [ ] S.T. [ ] Other: ____________________ [ ] For Eval: ____________________

DIETARY

Diet: ____________________ Supplement: ____________________

Tube Feeding: ____________________ Flush Tube With: ____________________ Freq: ____________________

Tube Type: ____________________ Size: ____________________ ft. Change: ____________________

MISC ANCILLARY ORDERS

1) ____________________ 4) ____________________

2) ____________________ 5) ____________________

3) ____________________ 6) ____________________

Resident has been made aware of his / her medical condition unless: [ ] Deemed Medically Inadvisable [ ] Incapable Of Understanding

SEE PROGRESS NOTES FOR ADDITIONAL COMMENTS

Rehab Potential: Good / Fair / Poor / Maintenance (circle) Prognosis: Good / Fair / Poor / Guarded (circle)

[ ] Admission of this resident recommended. Above orders approved. [ ] Above orders verified per telephone with physician.

Resident is at a ____________________ level of care. I approve of the comprehensive assessment plan of care and discharge plan.

PHYSICIAN AUTHORIZATION

Dispense Quantity: Sufficient for one month.

[ ] By signing below, I authorize the prescriptions listed above to be refilled as needed for one year.

[ ] By signing below, I authorize the prescriptions listed above to be refilled ____________________ times.

Physician	Telephone No.	Dispense As Written	Date	May Substitute	Date

Patient	Gender	Date of Birth	Patient No.	Room No.	Bed	Admission Date	Facility Code	Nurse's Signature	Date

Allergies	Diagnosis

SAMPLE

PHYSICIAN'S ORDER

MEDICATIONS	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR
☐ DO NOT SEND	HOUR

NON-MEDICATION ORDERS

PAY TYPE

Facility: ____________________

Date of Admission: ____________________ [ ] Medicare A

[ ] Private [ ] Insurance Provider: ____________________ * Send copy of insurance cards, front and back.

[ ] Medicaid # ____________________ [ ] Medicare Part D Plan: ____________________

[ ] Medicare # ____________________ Social Security # ____________________

Responsible Party = Name: ____________________ Phone: ____________________

Street: ____________________ City: ____________ State: ________ Zip: ________

MISCELLANEOUS

Sex: Male / Female (circle one)

Physician Name: ____________________ Alt. Physician: ____________________

Code Status: ____________________

LABORATORY

May Have Pneumovax Vaccine: [ ] Yes [ ] No LAB: ____________ Every ________ Due: ________

May Have Annual Flu Vaccine: [ ] Yes [ ] No LAB: ____________ Every ________ Due: ________

May Have Annual Mantoux: [ ] Yes [ ] No

SPECIALIZED SERVICES / THERAPY

[ ] P.T. [ ] O.T. [ ] S.T. [ ] Other: ____________________ [ ] For Eval: ____________

DIETARY

Diet: ____________________ Supplement: ____________________

Tube Feeding: ____________________ Flush Tube With: ____________ Freq: ____________

Tube Type: ____________ Size: ______ ft. Change: ____________

MISC ANCILLARY ORDERS

1) ____________________ 4) ____________________

2) ____________________ 5) ____________________

3) ____________________ 6) ____________________

Resident has been made aware of his / her medical condition unless: [ ] Deemed Medically Inadvisable [ ] Incapable Of Understanding

SEE PROGRESS NOTES FOR ADDITIONAL COMMENTS

Rehab Potential: Good / Fair / Poor / Maintenance (circle) Prognosis: Good / Fair / Poor / Guarded (circle)

[ ] Admission of this resident recommended. Above orders approved. [ ] Above orders verified per telephone with physician.

____

Resident is at a __________ level of care. I approve of the comprehensive assessment plan of care and discharge plan.

PHYSICIAN AUTHORIZATION

Dispense Quantity: Sufficient for one month.

[ ] By signing below, I authorize the prescriptions listed above to be refilled as needed for one year.

[ ] By signing below, I authorize the prescriptions listed above to be refilled _________ times.

Physician	Telephone No.	Dispense As Written	Date	May Substitute	Date

Patient	Gender	Date of Birth	Patient No.	Room No.	Bed	Admission Date	Facility Code	Nurse's Signature	Date

Allergies	Diagnosis

SAMPLE

MEDICATIONS	HOUR	MEDICATION / TREATMENT ADMINISTRATION RECORD																														
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☐ DO NOT SEND																																

Physician	Telephone No.	Dispense As Written	Date	May Substitute	Date

Patient	Gender	Date of Birth	Patient No.	Room No.	Bed	Admission Date	Facility Code	Nurse's Signature	Date

Allergies	Diagnosis

SAMPLE

MEDICATION / TREATMENT NOTES

Date	Hour	Comments / Notes	Initials

			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
VITAL SIGNS	TEMPERATURE																																
	PULSE																																
	RESPIRATION																																
	BLOOD PRESSURE																																
	BLOOD PRESSURE																																
	WEIGHT																																
INTAKE / OUTPUT	11-7	INTAKE																															
		OUTPUT																															
	7-3	INTAKE																															
		OUTPUT																															
	3-11	INTAKE																															
		OUTPUT																															
	TOTALS	INTAKE																															
		OUTPUT																															

INITIALS	FULL SIGNATURE & TITLE	INITIALS	FULL SIGNATURE & TITLE	INITIALS	FULL SIGNATURE & TITLE	INITIALS	FULL SIGNATURE & TITLE

SAMPLE