				PH'	YSICIAN'S ORDER	
MEDICATIONS	HOUR		NON-MEDI	CATION ORDERS		
	HOUR		PA	Y TYPE =====		
		Facility:				
		Date of Admission:		] Medicare A		
☐ DO NOT SEND		[ ] Private [ ] Insurance Provider:			* Send copy of insurance	e cards, front and back.
□ DO NOT 3END	HOUR	[ ] Medicaid #				
	HOOK	[ ] Medicare #	Sc	ocial Security #		
		Responsible Party = Name:		Phone:		
		Street:			State:	_Zip:
☐ DO NOT SEND			MISC	<b>ELLANEOUS</b>		
	HOUR	Sex: Male / Female (circle one)				
		Physician Name:	Alt. Physici	an:		
		Code Status:				
DO NOT CEND						
☐ DO NOT SEND	HOUR	May Have Pneumovax Vaccine: [ ] Yes				Due:
	HOUK	May Have Annual Flu Vaccine: [ ] Yes			Every	Due:
		May Have Annual Mantoux: [ ] Yes	[ ] No	SEDVICES / THEDAD	<b>′</b>	
			JECIALIZED			
☐ DO NOT SEND		[ ] P.T. [ ] O.T. [ ] S.T. [ ] Other:	_	[ ] For		
	HOUR					
		Diet:				
		Tube Feeding:				
		Tube Type: Size				
☐ DO NOT SEND						
	HOUR	1)	4)			
		2)	5)			
		3)	6)		11.11	
☐ DO NOT SEND	1	Resident has been made aware of his / he				
	HOUR		SEE PROGRESS NOTES	FOR ADDITIONAL CO	MMENTS =======	
		Rehab Potential: Good / Fair / Poor /	Maintenance ( circle )	Prognosis: Good /	Fair / Poor / Guarded (c	ircle)
		[ ] Admission of this resident recommend	ded. Above orders approved.	[ ] Above orders	verified per telephone wit	h physician.
			6.1			
☐ DO NOT SEND		Resident is at a level of care. I				
	HOUR			UTHORIZATION ====		
		Dispense Quantity: Sufficient for one mon				
		By signing below, I authorize the pre-	•	•	/ear.	
☐ DO NOT SEND		By signing below, I authorize the pre-	scriptions listed above to be r	refilledtimes.		
Physician	Telephone No.	Dispense As Written	Date	May Substitute		Date
Pationt	Candar	Date of Birth Dationt No. Decre N.	Rod Admission Date	Facility Code Nurse's Signat	uro	Dato
Patient	Gender	Date of Birth Patient No. Room No.	o. Bed Admission Date	racility code   Nurses Signat	uie	Date
Allergies		Diag	nosis			

						<b>PHYSICI</b>	AN'S ORDER	
MEDICATIONS	HOUR			NON-MEDI	CATION OF	RDERS		
	HOUR	=======================================		====== PA	TYPE ==			
		Facility:						
		Date of Admission:			Medicare A			
_							nd copy of insurance	cards, front and back.
☐ DO NOT SEND		[ ] Medicaid #						,
	HOUR	[ ] Medicare #						
		Responsible Party = Name:			V	Phone:		<del></del>
		Street:				State	2	— 7in·
☐ DO NOT SEND		=======================================						
DO NOT SEND	HOUR	Sex: Male / Female ( circle one )						
	HOOK	Physician Name:		Alt. Physicia	ın:			
		Code Status:						
				====== LAE	ORATORY			
☐ DO NOT SEND		May Have Pneumovax Vaccine:	1 Yes				Everv	Due:
	HOUR	May Have Annual Flu Vaccine: [		] No LAB:				Due:
		May Have Annual Mantoux:		] No				
				SPECIALIZED	SERVICES	/ THERAPY ====		
		[ ] P.T. [ ] O.T. [ ] S.T. [ ] Ot						
☐ DO NOT SEND			illei.	DI	ETA DV	[ ] TOT EVAI		<del></del>
	HOUR							
		Diet:						
		Tube Feeding:						
_		Tube Type:	_ Size:	tt. Change:				
☐ DO NOT SEND			<del>-   </del>	IIII T				
	HOUR	1)	<u> </u>	4)_				
		2)						
		3)						<u></u>
☐ DO NOT SEND		Resident has been made aware of hi	is / her medic	cal condition unless:	[ ] Deeme	ed Medically Inadvisa	ble [ ] Incapab	le Of Understanding
DO NOT SEND	HOUR		==== SEE F	PROGRESS NOTES I	OR ADDIT	TIONAL COMMEN	TS ======	
	HOOK	Rehab Potential: Good / Fair / Po	oor / Mainto	ananco (circla)	Prognosi	is: Good / Fair / P	Poor / Guarded ( circ	clo.)
		[ ] Admission of this resident recom					d per telephone with	
			illilellueu. Al	bove orders approved.	[ ] /	Above orders verified	per telephone with	————
☐ DO NOT SEND		Resident is at a level of	care. I appro	ove of the comprehensiv	e assessmer	nt plan of care and di	scharge plan.	
	HOUR			=== PHYSICIAN AU	ITHORIZAT	TION		
		Dispense Quantity: Sufficient for one			)			
		By signing below, I authorize the		ons listed above to be re	afillad as naa	ided for one year		
		By signing below, I authorize the				times.		
☐ DO NOT SEND			ic prescriptio					
Physician	Telephone No	Dispense As Written		Date	٨	May Substitute		Date
Patient	Gender	Date of Birth Patient No. R	loom No. Be	ed Admission Date	Facility Code	Nurse's Signature		Date
Allergies			Diagnosis					

MEDICATIONS	HOUR	HOUR MEDICATION / TREATMENT ADMINISTRATION RECORD																												
	HOOK				, i																									
	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
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☐ DO NOT SEND		7																												
ician	Telephone No			C	Dispens	e As Writt	en						Da	te			-	May	Substi	tute							Dat	te		
ent	Gender	Date	of Birt	h		Patient N	0.	Ro	om No	0.	Bed	Adm	ission	Date		Facil	lity Co	de N	urse's :	Signatu	ure						Da	ate		
gies									Diagr	nosis																				

## **MEDICATION / TREATMENT NOTES**

Date	Hour	Comments / Notes															Init	ials														
																		-		-			4	·								
TEM	PERATURE	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
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