2715 East Jackson Blvd. • Elkhart, Indiana 46516 • 574-293-6886 • Fax 574-295-9290

PHYSICIAN'S ORDER

Patient ____ Date: _______________

Diagnosis: ____

Allergies (food, medications or pets): ____

Hospital Preference: ____

What is the patient's physical pain on a scale of 1 to 5? _________

Diet Order (please check appropriate boxes below)

- ☐ Regular
- ☐ Diabetic (please indicate calorie count) * ☐ 1800 ☐ 2000
- ☐ No concentrated sweets
- ☐ Low fat/low cholesterol
- ☐ No added salt
- ☐ Mechanical soft

Most Recent: Blood Pressure ___________ Pulse _____________ Weight ________

TB/Mantoux: Date given_______________ Results/Date read ___________

Given by: _____________________________ Read by: ____________________________

Does patient wander away from home or indicate a potential to wander?	☐ Yes	☐ No
To your knowledge is patient free from communicable disease?	☐ Yes	☐ No
Do you think patient will benefit from enrollment?	☐ Yes	☐ No
Is patient combative?	☐ Yes	☐ No
Can the patient self-administer medications?	☐ Yes	☐ No
May this patient take part in range of motion activities?	☐ Yes	☐ No

Limitations?

Print or type
Physician's Name ____

Address ____

____

Phone _______________________ Fax ____________________________

Physician's signature ___________________________________ Date____________
UPIN#________

FOR RIVERVIEW ADULT DAY CENTER OFFICE USE ONLY
Advance Directives included in chart ☐ YES ☐ NO

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Medication List

Patient's Name________________________________

NOTE: Please include PRN and over the counter items

MEDICATION LIST

Name of Medication	Dosage	Times Given	Reason Given

Physician's permission for facility to:

Apply sunscreen? ☐ Yes ☐ No

Clip fingernails? ☐ Yes ☐ No

Physician's signature: ________________________________ **Date:** ____________