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: _____**