HALE NOHEA
Maunalani

PHYSICIAN ORDERS

Resident Name:_____ Date:_____

Diet Order:
Type of diet, _____
___4 gram Na or NO Added Salt (NAS) ___2 gram Na
___NCEP Step I ___NCEP Step II
___ _____calorie diabetic diet (ADA)
___Low Fat
___Other:_____
_____

Level of Care: ___Independent Living ___ARCH ___ICF ___SNF

Activity Orders:
Ambulation: ___Ambulatory without Assistance ___Walker ___Cane ___W/C
Passes: ___May go on a day-pass without Supervision for a maximum period of _____hours.
___May go on day-pass with Supervision for a maximum period of _____hours.
Restraints: ___Seat Belt W/C ___Side-rails _____ ___Lap Tables ___Other:_____

Medications, Vitamins and Supplements:
(Please include Drug name, dosage, route, and frequency)

Other:

Date:_____ **Physician Name / Signature:**_____

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