



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.
Restrains: ___ 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:** _____