RIVERVIEW ADULT DAY CENTER

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 ______________________________

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? ______________________________

FOR RIVERVIEW ADULT DAY CENTER OFFICE USE ONLY

Advance Directives included in chart ☐ YES ☐ NO

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Physician's Order

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:** ___________