



DIRECT ADMISSION ORDERS

Call Bed Coordinator for bed assignment: 224-783-8169

NOTE: Orders with a "☐" are choices and are NOT ordered unless checked.

PATIENT INFORMATION		PHYSICIAN INFORMATION		
Last Name		Admitting Physician		
First Name	MI	Phone Number	Fax Number	NPI Number
Birth Date:		<input type="checkbox"/> Admit Inpatient <input type="checkbox"/> Observation	Location: <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Telemetry	<input type="checkbox"/> ICU <input type="checkbox"/> OB Med Monitor

DIAGNOSES:
 1) _____ 2) _____ 3) _____ 4) _____

CONSULTANT(S): _____

ALLERGIES: _____ NKDA

Medication Intolerances: _____

<p>ACTIVITY</p> <input type="checkbox"/> Ad lib <input type="checkbox"/> Bed rest <input type="checkbox"/> Bathroom privileges <input type="checkbox"/> Bedside commode <input type="checkbox"/> Head of bed > 30° <input type="checkbox"/> Assist patient with all movement <input type="checkbox"/> Sit patient on edge of bed every shift <input type="checkbox"/> Ambulate patient every shift <p>DIET</p> <input type="checkbox"/> Regular <input type="checkbox"/> Mechanical soft <input type="checkbox"/> Pureed <input type="checkbox"/> Full liquids <input type="checkbox"/> Clear liquids <input type="checkbox"/> Cardiac (low fat, low cholesterol) <input type="checkbox"/> Low sodium _____ grams <input type="checkbox"/> Low residue, low fiber <input type="checkbox"/> Other _____	<p>VITAL SIGNS</p> <input type="checkbox"/> Every shift <input type="checkbox"/> Every 4 hours <input type="checkbox"/> Per critical care protocol <input type="checkbox"/> Neuro checks every _____ hours <p>NURSING</p> <input type="checkbox"/> Fall precautions <input type="checkbox"/> Diapers <input type="checkbox"/> Daily weights <input type="checkbox"/> Strict intake and output <input type="checkbox"/> Accuchecks: <input type="checkbox"/> Before every meal & at bed time <input type="checkbox"/> Every 6 hours (if nothing by mouth) <input type="checkbox"/> Other: _____ <p>IV Fluids</p> <input type="checkbox"/> Fluid _____ with _____ additives @ _____ mL/hour <input type="checkbox"/> Heparin lock - flush every shift with saline <input type="checkbox"/> Other: _____
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DIAGNOSTIC TESTS: Obtain: STAT AM PM

<input type="checkbox"/> Basic metabolic panel	<input type="checkbox"/> Type and screen	<input type="checkbox"/> Arterial blood gas
<input type="checkbox"/> Comprehensive metabolic panel	<input type="checkbox"/> CK-MB/troponin every 8 hours x 3	<input type="checkbox"/> Blood culture x 2
<input type="checkbox"/> CBC	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Electrocardiogram
<input type="checkbox"/> PT/INR <input type="checkbox"/> PTT	<input type="checkbox"/> Urine culture	<input type="checkbox"/> Chest x-ray posterior-anterior & lateral
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Chest x-ray - portable

MEDICATIONS: _____

Other Orders: _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

GIVE COMPLETED ORDERS TO PATIENT TO HAND CARRY

