

PHYSICIAN'S ORDERS

ANOTHER BRAND OF DRUG IDENTICAL IN FORM AND ~
CONTENT MAY BE DISPENSED UNLESS CHECKED

Date & Time Ordered	PSYCHIATRIC ADMISSION ORDERS	Page 1 of 3
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- Date/Time _____
1. **Admit to:** _____
Primary Care MD _____
Consult: MH on Call Dr. _____
 CMC Other _____
 Previous medical record to department
 No open chart – reason: _____
 2. **Diagnosis:** (DSM-IV) _____
 3. Legal Status: A) Voluntary B) Involuntary Paperwork initiated Date: _____
 County Atty Notified Date: _____
 Paperwork filed w/Court Date: _____
[Copy placed on chart]
 4. **Allergies:** _____

 5. Treatment Setting:
9 Regular Room or _____ (if available)
9 Room E11 - Door Open
9 Room E11 - Door Locked (If this category checked, all of the following apply):
Patient placed in locked seclusion / restraint (check one) for the purpose of:
9 no other less restrictive measure is appropriate per assessment
9 potential danger to self or others
9 behavior is not manageable within the care environment
If patient is in a locked room and restrained they must have continuous face-to-face monitoring.
 6. **CPR status:** No Code Full Code Other _____
 7. **Vital Signs:**
Every shift x _____ hrs, then once per day 9 _____
9 Orthostatics upon admit
 8. **Labs:**

 8. **Diet:** _____
9 Paper and plastic utensils 9 Finger foods x _____ hrs 9 No restrictions

Physician Signature _____



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11. Referrals

- | | |
|---|--|
| <input type="checkbox"/> Rehab Services; evaluate and treat | <input type="checkbox"/> Wound Care Consult |
| <input type="checkbox"/> PT | <input type="checkbox"/> Hospice Consult |
| <input type="checkbox"/> OT | <input type="checkbox"/> Long Term Care Consult |
| <input type="checkbox"/> ST | <input type="checkbox"/> Financial Consult |
| <input type="checkbox"/> Complimentary Medicine Consult | <input type="checkbox"/> Dietary Consult _____ |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Diabetic Consult |
| <input type="checkbox"/> Healing Touch | <input type="checkbox"/> CMC Consult |
| <input type="checkbox"/> Pet Therapy | <input type="checkbox"/> Case Management Consult _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Cardiopulmonary Consult |
| <input type="checkbox"/> Home Health Consult | <input type="checkbox"/> Other _____ |

Physician Signature _____

