Authorization is hereby given to dispense the generic chemical equivalent unless otherwise indicated by the physician.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Physician’s Orders and Signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I certify that inpatient hospital services are necessary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place in observation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place in outpatient surgery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place in outpatient services.</td>
</tr>
</tbody>
</table>

Check One: □ Med/Surg □ Telemetry □ ICU □ PCU/Step Down □ OB

Admitting Physician: ____________________________
Admit Diagnosis: ____________________________

The patient care/case has been discussed with Dr. ____________________________ who agrees to assume the care of the patient. Call Admitting physician immediately for further orders, clarification of orders or change in patient’s condition. If patient has not been evaluated by Admitting Physician, review these orders with the Admitting Physician immediately on arrival or at ______am/pm.

Consults:

[ ] upon arrival/[ ] in AM for ____________________________

Diet:

□ Regular □ Clear Liquid
□ Cardiac □ NPO
□ Diabetic (____cal) □ NPO after MN
□ Renal

02:

□ Room Air
□ NC @ ______ L/min
□ Venturi Mask ______ %
□ 100% Non-rebreather

Activity:

□ As Tolerated
□ Per Attending MD
□ Bedrest

IV Access:

□ IV Lock
□ IV Fluids @

Foley Cath to gravity:

□

Insulin:

□ Listed under Medications
□ Sliding Scale – For glucose levels > 160, ((Glucose Level-100)/25)=Units Regular Insulin sq

Medications:

1. __________________________________________ 3. __________________________________________
2. __________________________________________ 4. __________________________________________

Additional Orders:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

These orders expire in ________ hours.

Signature: ____________________________

Place Patient Sticker Here