THE UNIVERSITY OF KANSAS HOSPITAL
KUMED
3901 Rainbow Boulevard
Kansas City, Kansas 66160

**PHYSICIAN'S ORDER FORM**

Do not write in this box

DT0017

PATIENT LABEL

| DATE & TIME | # | ORDERS<br>REHABILITATION UNIT ORTHOPEDIC |
|---|---|---|
| | | **Reference:** |
| | | **Allergies:**___________________________________________ **Patient Weight:** _____________kg |
| | 1. | **Admit to:** Rehabilitation Nursing Unit |
| | 2. | **Attending Physician:** **Pager:**<br>**Resident Physician:** **Pager:** |
| | 3. | **Diagnosis:** |
| | 4. | **Code Status:** ☐ Full Code ☐ Other Status___________________________________________________ |
| | 5. | **Activity:** ☐ Out of Bed as tolerated<br>☐ Out of Bed for _________hours _________ times/day<br>☐ To Dining Room for lunch / dinner<br>☐ Other: ___________________________ |
| | 6. | **Weight Bearing Restrictions:** ☐ NO ☐ YES (specify limb) ________________________<br>Weight Bearing Percent: ________ |
| | 7. | **Diet:** ______________________________<br>☐ Aspiration Precautions<br>☐ Supervision at mealtimes |
| | 8. | **Vital Signs:** ☐ Every 12 hours ☐ Other___________________________________________________ |
| | 9. | **Nursing:**<br>• Weigh on admission and weekly<br>☐ Fingerstick Blood Glucose q ________________<br><br>Skin Care:<br>☐ Special Mattress: Type __________________________________________________<br>Wound Care:<br>☐ Site: Frequency: ☐ Q-day ☐ BID ☐ TID ☐ Other Care:<br>☐ Site: Frequency: Care:<br>☐ Site: Frequency: Care: |
| | 10. | **Respiratory:**<br>☐ 02 Needs<br>☐ Treatment Needs |
| | 11. | **Laboratory:** |
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| | 12. | Bladder Program:<br>☐ Foley Catheter to DD ☐ Intermittent Catheterization every __________hours<br>☐ Time Void every ______ hours<br>☐ Other: ___________________________________ |
| | 13. | Safety Strategies:<br>☐ Restraints: Enclosure Bed or Posey: See Restraint Order Form<br>☐ High –low bed ☐ CO<br>☐ Patient Alarm System |
| | 14. | Mechanical DVT Prophylaxis:<br>☐ Sequential compression device to bilateral lower extremities when in bed<br>☐ Other:___________________________________ |
| | 15. | **Consults:**<br>☐ Consult Wound Care Team. Reason:__________________________<br>☐ Notify Social Worker/Case Manager: Social Support/Financial/Discharge Issues _______________<br>☐ Nutrition Consult. Reason: ________________________________________<br>☐ Other _______________ |
| | 16. | Occupational Therapy: Evaluate & Treat for:<br>☐ ADLs / Adaptive Equipment recommendations ☐ Patient/family education<br>☐ Upper Extremity ROM/ Strength/coordination ☐ Visual Perception<br>☐ Upper extremity splinting (specify) ________________________________________<br>☐ Upper extremity electrical-stimulation (specify) _____________________ ☐ Other ______________ |
| | 17. | Physical Therapy: Evaluate & treat for:<br>☐ WC mobility skills ☐ Gait<br>☐ Transfers ☐ Lower extremity ROM/ strengthening ☐ Other _______________ |
| | 18. | Speech Therapy: Evaluate & Treat for:<br>☐ Communication ☐ Follow up with speaking valve<br>☐ Dysphagia ☐ Cognition ☐ Other _______________ |
| | 19. | Neuropsychology: Evaluate & Treat for:<br>☐ Coping ☐ Cognition ☐ Other:_____________________________________ |
| | 20. | Therapeutic Recreation: ☐ Evaluate & Treat ☐ Other ______________________________ |
| | 21. | **Call physician for:**<br>☐ SBP <90 >150 mmHg ☐ Any decrease in neurological status<br>☐ HR <50 > 120 Bpm ☐ Temp > 38.5<br>☐ Respiratory rate > 26 ☐ SaO2 < 90%<br>☐ Uncontrolled agitation ☐ Other _______________ |
| | 22. | **From Acute Care follow up appointments: Service/Name: Date: Time:** |
| | | |
| | | |

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| | 23. | **Medications:** |
| | | Bowel Medications: (Must write for specific medication/ dosage) |
| | | |
| | | Pain: (Must write for specific medication/ dosage) |
| | | |
| | | DVT Prophylaxis: (Must write for specific medication/ dosage) |
| | | |
| | | Other: (Must write for specific medication/ dosage) |
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Physician Signature: ______________________________ Pager: ____________