



THE UNIVERSITY
OF KANSAS HOSPITAL
KUMED

3901 Rainbow Boulevard
Kansas City, Kansas 66160

Do not write in this box



DT0017

PATIENT LABEL

PHYSICIAN'S ORDER FORM

DATE & TIME	#	ORDERS REHABILITATION UNIT STROKE
		Reference: _____
		Allergies: _____ Patient Weight: _____ kg
	1.	Admit to: Rehabilitation Nursing Unit
	2.	Attending Physician: _____ Pager: _____ Resident Physician: _____ Pager: _____
	3.	Diagnosis: _____
	4.	Code Status: <input type="checkbox"/> Full Code <input type="checkbox"/> Other Status _____
	5.	Activity: <input type="checkbox"/> Out of Bed as tolerated <input type="checkbox"/> Out of Bed for _____ hours _____ times/day <input type="checkbox"/> To Dining Room for lunch / dinner <input type="checkbox"/> Other: _____
	6.	Diet: _____ <input type="checkbox"/> Aspiration Precautions <input type="checkbox"/> Supervision at mealtimes
	7.	Vital Signs: <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Other _____
	8.	Nursing: • Weigh on admission and weekly <input type="checkbox"/> Fingertick Blood Glucose q _____ Skin Care: <input type="checkbox"/> Special Mattress: Type _____ Wound Care: <input type="checkbox"/> Site: _____ Frequency: <input type="checkbox"/> Q-day Care: _____ <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> Other <input type="checkbox"/> Site: _____ Frequency: _____ Care: _____ <input type="checkbox"/> Site: _____ Frequency: _____ Care: _____
	9..	Respiratory: <input type="checkbox"/> O2 Needs <input type="checkbox"/> Treatment Needs
	10.	Laboratory:

REHABILITATION UNIT STROKE

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