**INPATIENT FACILITY - PHYSICIAN ORDERS**

**NAME OF FACILITY:** _______________________________________________

- [ ] Initial orders  
- [ ] Renewal of orders

Patient admitted to:  
- [ ] Northern Office  
- [ ] Southern Office

Date of Admission ________ These orders cover the period of time from ________ to _______

Physician __________________________________________________________________________

Hospice Diagnosis: ______________________________ Allergies ____________________________

### ORDERS

**Doctor: Please review and sign below**

1. [ ] Nursing 1–3x/wk & prn as needed for reassessment.
2. [ ] Home Health Aide 1-5 x/wk.
3. [ ] Physical Therapy _____x/wk.
4. [ ] Occupational Therapy _____x/wk.
5. [ ] Speech Therapy _____x/wk.
6. [ ] Social Work/Chaplain as indicated on IDT plan of care to support patient/family.
7. [ ] Volunteer.
8. [ ] Diet: ________________________________
9. [ ] Activity: ________________________________
10. [ ] Facilitate appropriate discharge plan_____________________________________________

### Present Patient/Family Status

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

### Therapeutic Goals

- [ ] Maintain patient’s comfort and dignity through death. Other: ________________________________

### Hospice Certification

I certify that this patient has a terminal illness with a prognosis of 6 months or less if the terminal illness runs its normal course.

### DNR Status

DO NOT RESUSCITATE ORDER IN EFFECT:  
- [ ] YES  
- [ ] NO

<table>
<thead>
<tr>
<th>Signature of Nurse Receiving Orders</th>
<th>Date</th>
<th>Signature of Physician</th>
<th>Date</th>
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</thead>
</table>

**Physician: Please sign and return within 48 hours**