

GENERIC SUBSTITUTE UNLESS CHECKED

**ORDERS ARE IN EFFECT UNLESS CROSSED OUT.**  
Exceptions: Orders preceded by a box () require a ✓ to initiate order.  
Orders with blanks indicate additional information is needed.

\*Patient name: \_\_\_\_\_ \*DOB: \_\_\_\_\_

\*Date \_\_\_\_\_ \*Diagnosis and ICD-10 code: \_\_\_\_\_

Allergies: \_\_\_\_\_

\*Time \_\_\_\_\_

Outpatient admit:  Series  One time

Code status:  Full code  DNR  Medications only  Other (specify) \_\_\_\_\_

Vital signs:  Per protocol  Other (specify)

Lab draws:  CBC  CMP  CRP  PT  ESR  Albumin  A1C  
 Other (specify) \_\_\_\_\_

Vascular access:  Port  PICC  CVC  Start SL

Frequency of lab test(s):  One-time order  Weekly  Twice monthly  Monthly  
 Other (specify) \_\_\_\_\_

Collect wound cultures as needed and fax results to: \_\_\_\_\_

**Please have patient evaluated and treated by wound care RN**

Additional orders: \_\_\_\_\_

\_\_\_\_\_  
\*Physician signature

\_\_\_\_\_  
\*Date

\_\_\_\_\_  
\*Time

**\*Denotes field that must be completed by healthcare worker**

**FAX order form to 503-815-7515**



Physician Order

Physician Order: Wound Care  
Adventist Health Tillamook  
1000 Third St., Tillamook OR 97141

{ Patient label }