	***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	* Date of Birth		
* Date	* Diagnosis			
	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	❑ Hgb & Hct ❑ Other (SPECIFY) _____
		❑ PT	❑ ESR	❑ Albumin _____
	Vascular Access	❑ Port	❑ PICC	❑ CVC ❑ Start SL
	Frequency of lab test(s)	❑ One time order	❑ Weekly	❑ Twice Monthly ❑ Monthly
		❑ Other (SPECIFY)		
	❑ Please have patient evaluated by Wound Care RN			
	Additional Orders			
	Frequency	❑ One time order	❑ Biweekly	❑ Weekly ❑ Monthly
		❑ Other (SPECIFY)		
	* Healthcare Provider's Signature _____			

- * Denotes field that must be completed by Healthcare worker

Fax to 503-815-7515

[Patient Label]