**PHYSICIAN ORDERS**

**ADMISSION / TRANSFER**

**INPATIENT, ED & ANCILLARY DEPARTMENTS**

1. Write in date and time.
2. Enter prescribed dose and prescribed interval for each medication.
3. Please print name, sign order and include pager number.
4. Required information, designated by bold type, must be provided before medication can be dispensed or administered.
5. Pediatric orders require dose / weight (mg / kg) format.

<table>
<thead>
<tr>
<th>PRINT PATIENT NAME:</th>
<th>WEIGHT (kg):</th>
<th>Initial to Indicate if:</th>
<th>New Admission or</th>
<th>Transfer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Admit to Dr / Unit:</th>
<th>Transfer to Dr / Unit:</th>
</tr>
</thead>
</table>

**Demographic Information in this section not required for patient transfers unless change has occurred since admission:**

- **Diagnoses:** __________
- **Condition:** __________
- **Code Status:** __________
- **Initial to Indicate:** Pregnant: __________
- **Yes** | **No**
- **Breastfeeding:** __________
- **Yes** | **No**
- **Vaccinations:** Initial if current: __________
- **Influenza** | **Pneumococcal**

**Allergies and Reactions:**

- **Comorbid Conditions (Initial to Indicate):** __________
- **Cardiac (ACS, CHF, AFIB)** | **Diabetes Mellitus** | **Renal** | **Hepatic** | **Respiratory**
- **Vital Signs:** __________
- **Sex:** __________
- **Activity:** __________

**Nursing / Respiratory Treatments:**

<table>
<thead>
<tr>
<th>Laboratory:</th>
</tr>
</thead>
</table>

**Diagnostic Tests with Justifying Signs / Symptoms:**

**PRESCRIBERS, PLEASE NOTE:**

1. In order to comply with current Medicare mandates, this patient will be evaluated for Influenza and Pneumococcal vaccine eligibility. If this patient meets the approved criteria, vaccine will be administered unless you indicate otherwise. If you DO NOT wish for this patient to receive either of the mandated vaccines, please initial: **DO NOT ADMINISTER:** __________

2. Automatic therapeutic interchange for specific medications, approved by the P&T committee, is permitted for all applicable medication orders unless the order contains special instructions stating "Do Not Interchange." The current approved therapeutic interchange list is available on the SAH Intranet Pharmacy homepage.

**MEDICATION OR IV FLUID (no abbreviations)**

<table>
<thead>
<tr>
<th>Dose / Volume</th>
<th>Route</th>
<th>Freq</th>
<th>Indication / Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>__________</td>
<td>__________</td>
<td>_______________________________</td>
</tr>
</tbody>
</table>

**PRESCRIBER: __________**

**ORDER TO PHARMACY: **

**NURSE: __________**

**ORDER RECALLED: __________**

**Date: __________**

**Time: __________**

**MD Print Name: __________**

**MD Signature: __________**

**MD Expert Contact: __________**

**704-290-9584 (FAX): **

**ORIGINAL - CHART**

**COPY - PHARMACY**