MERIDIAN of Temple

Patient First Name: _____ **Last Name:** _____

DOB: _____

1. Admit to: Skilled Nursing

2. PCP: _____

   Phone #: _____

3. Primary Diagnosis: _____

4. Allergies: _____

5. Activity:

   ☐ Ad lib ☐ Bed rest

   ☐ Bed rest with bathroom privileges/assistance

   ☐ Restrictions: _____

   _____

6. Diet/Nutrition:

   ☐ Regular ☐ Diabetic ☐ Low sodium ☐ Soft

   ☐ Puree ☐ NPO ☐ Thickened liquids

   ☐ Tube feed/Other: _____

7. Advance Directives:

   ☐ Full code

   ☐ Do not resuscitate/Do not intubate

   ☐ Modified/other: _____

8. Therapy: ☐ PT ☐ OT ☐ ST

9. Wound care:

   Wound care orders attached: ☐ Yes ☐ No

   Wound location: _____

   Other instructions/dressing: _____

   _____

   _____

10. Other care:

    ☐ X-ray: _____

    ☐ IV fluids: _____

    ☐ IV meds: _____

    ☐ RT: _____

    Copy of medications list attached:

    ☐ Yes ☐ No

    To the care of a Facility Physician:

    ☐ Yes ☐ No

11. To the care of:

    Dr./Group _____

    Phone #: _____

Additional Orders: _____

_____

_____

Physician Name (Please Print) : _____ **Date:** _____

Physician Signature: _____

Phone: (254) 771-1226 Fax: (254) 771-3432

4312 S. 31st Street, Temple, TX 76502 MeridianofTemple.com