Time:__________________

PATIENT NAME:	DOS:	ROOM#:
DOB:	LAST DOS:	☐ LAB CORP ☐ QUEST
REFERRING DOCTOR/PCP:		

REASON FOR VISIT/CHIEF COMPLAINT:

☐ NEW ☐ FOLLOW-UP
☐ VA ☐ HOSPITAL F/U

VITAL SIGNS:	BP:	P:	TEMP:	RR: O2 %:	WEIGHT: HEIGHT:

IN HOUSE LABS	***INJECTIONS***	***IN HOUSE MEDICATIONS***
☐ RAPID STREP	☐ METHYLPREDNISOLONE 40mg	☐ CLONIDINE 0.1MG
☐ FLU SWAB	☐ B12 1000mcg	☐ NITRO SL 0.4MG
☐ ACCU CHECK	☐ KETOROLAC 60mg	☐ ASA 325 MG
☐ URINE DIP	☐ ROCEPHIN (CEFTRIAXONE) 1gm	☐ DIPHENHYDRAMINE 50MG
☐ URINE PREG	☐ EPI-PEN	☐ ORANGE JUICE
☐ MONOSPOT	***PROCEDURES***	☐ DUO NEB (IPRATROPIUM BROMIDE + ALBUTEROL INHALED)
☐ STOOL GUIAC	☐ EKG	
☐ INR POC	☐ PFTs	
☐ PPD 0.1 ML ID	☐ CERUMEN REMOVAL	☐ 1L NS BOLUS
VACCINES	IMAGING	PATIENT EDUCATION
☐ INFLUENZA	☐ XRAY:	☐ LOW SALT DIET
☐ PREVNAR PCV 13	☐ SONO:	☐ ADA 1800 DIET
☐ PPSV 23	☐ CT:	☐ GERD
☐ TETANUS (DTAP)	☐ MRI:	☐ HIGH CSL
☐ HEP-B 3 SERIES	☐ MAMMOGRAM	☐ CARDIAC DIET
☐ MENINGITIS	☐ DEXA	☐ POTASSIUM DIET
☐ HPV GARDISIL	☐ DOPPLER	☐ PHOSPHORUS DIET
☐ SHINGLES	☐ MRA	☐ COUMADIN DIET
		☐ EXERCISE

ORDERS:

RETURN VISIT:	_______WEEKS	_______MONTHS	☐ 1 YEAR	☐ PRN	____________________

DOCTOR SIGNATURE: ______________________________