PHYSICIAN ORDERS Name of ARCH:_____

Resident Name: _____ *Date:* _____

Diet Order: _____

Level of Care: ☐ Independent Living ☐ ARCH ☐ ICF ☐ SNF

Activity Orders:
Ambulation: ☐ Ambulatory without Assistance ☐ Walker ☐ Cane ☐ W/C
Passes: ☐ May go on a day-pass without Supervision for a maximum period of _____hours.
☐ May go on day-pass with Supervision for a maximum period of _____hours.
Restraints: ☐ Seat Belt W/C ☐ Side-rails _____ ☐ Lap Tables ☐ Other: _____

Medications, Vitamins and Supplements:
(Please include Drug name, dosage, route, and frequency)

Other:

Date: _____Physician Name / Signature: _____