Adventist Health Tillamook

Physician Order
Wound Care

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:** _____ ***DOB:** _____

_____
*Date

***Diagnosis and ICD-10 code:** _____

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 ☐ CRP ☐ PT ☐ ESR ☐ Albumin ☐ A1C
☐ Other (specify) _____

Vascular access: ☐ Port ☐ PICC ☐ CVC ☐ Start SL

Frequency of lab test(s): ☐ One-time order ☐ Weekly ☐ Twice monthly ☐ Monthly
☐ Other (specify) _____

Collect wound cultures as needed and fax results to: _____

Please have patient evaluated and treated by wound care RN

Additional orders: _____

_____

_____

***Healthcare provider's signature:** _____

***Denotes field that must be completed by healthcare worker**

FAX order form to 503-815-7515

Physician Order Form: Wound Care

{ Patient label }

Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

070-00601 01/23