HALE MAKUA HEALTH SERVICES
COMPASSION COMMITMENT COMMUNITY

Adult Day Health Program

Name:	DOB:
Attending Physician:	
Code Status: ☐ Code ☐ No Code	
Allergies/Adverse Drug Reactions:	
H & P: (Please attach)	

Diagnosis List

Goals of Care:

Evaluate for: ☐MEP (maintenance exercise program)	Weight Bearing Status:

Diet: ☐Regular ☐NAS ☐1800 Kcal ADA ☐NCS ☐Low Salt ☐Low Cholesterol ☐Renal
Texture: ☐Regular ☐Minced ☐Ground ☐Pureed ☐Other _____

Fluids: ☐Thin ☐Nectar ☐Honey ☐Pudding ☐FR	Activity Level ☐As tolerated ☐Other: _____
Weights: ☐Daily ☐Weekly ☐Monthly ☐Other	

TB skin test:
On admission & annually per policy unless client has documented positive TB skin test.

Other Orders:

Medication	Dosage	Route	Frequency	Diagnosis

PHYSICIAN'S SIGNATURE	DATE	TIME

Admission Physician's Order Sheet

Please return to patient or mail to: Hale Makua Day Health
472 Kaulana Street
Kahului, HI 96732