

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: _____