Do NOT Use Abbreviations
Write Clearly

ADMIT STATUS
701

Revised 09/2014

Instructions: All orders are to be implemented unless crossed through by the ordering provider.
Exception: Orders with ❑ must be checked to be implemented.
Any changes to the order set must be initialed by the ordering provider, e.g. deletions or additions

Patient Status: *(Choose ONE)*
☐ Inpatient ☐ Outpt Procedure (SDC) ☐ Outpt Begin Observation

Diagnosis: ______________________________

Unit Type: ☐ Critical Care ☐ Gynecology ☐ Obstetrics ☐ Surgery
☐ General ☐ Intermediate ☐ Oncology ☐ Telemetry

Unit Preferred: ______________________________

Attending/Admitting Physician: ______________________________

Service/Group MUST be accurate for rounding reports

Will attending/admitting physician see patient on behalf of one of the following: *(if not, skip)*

☐ Grace Med Hlth Clin ☐ Hunter Peds Clinic ☐ Peds Trauma ☐ WMC Ortho Clinic
☐ Hunter Clinic ☐ KU Hospitalist/Med 1 ☐ Trauma (Not Ortho) ☐ WMC Surgery Clinic
☐ Hunter OB Clinic ☐ KU Newborn Clinic ☐ WMC Fam Med OB Clinic ☐ WMC Women's Clinic

ED Patients ONLY

Pneumonia: ☐ Yes ☐ No **Heart Failure:** ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No **Focal Neuro Deficit** *(TIA,CVA,Bleed)*: ☐ Yes ☐ No
Sepsis: ☐ Yes ☐ No → **If yes:** ☐ Severe Sepsis *Or* ☐ Septic Shock
Chest Discomfort *(STEMI,AMI,ACS)*: ☐ Yes ☐ No → **If yes:** ☐ Active *Or* ☐ Resolved
Special Precautions: ☐ Airborne (TB,Chknpox,et) ☐ Contact (MRSA,C-Diff,et) ☐ Droplet (Mumps,Influ,et)
Specialty Bed: ☐ Bariatric ☐ Clinitron ☐ Low Air Loss/Low Pressure

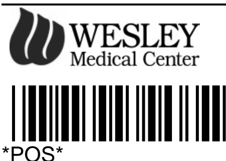
NURSING ORDERS may be initiated by RN after assessing patient condition

I certify that the patient status is appropriate and is based on my best clinical judgment and the patient's condition as documented in the medical record.

TORB______________________________ ____/_____/_____ ____________
RN Signature Date Time

______________________ ______________________ ____/_____/_____ ____________
ED Physician/Resident Physician Provider # Date Time

______________________ ______________________ ____/_____/_____ ____________
Physician Signature (Signature Level Provider) Physician Provider # Date Time



Patient Identification

MR701 (R09.14)