

Do NOT Use Abbreviations  
Write Clearly

**ADMIT STATUS**  
**# 701**

Revised 07/2017

**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**

Expect patient to be here equal to or greater than two midnights:  Yes  No  
May need to complete Medicare Order Form if expected stay less than two midnights

Patient Status:  Admit to Inpatient  Place in Outpatient  OP begin Observation

Diagnosis: \_\_\_\_\_

Unit Type:  Critical Care  Intermediate  Ortho  Stroke  Trauma  
 General  Obstetrics  Pediatrics  Surgery  
 Gynecology  Oncology  PICU  Telemetry

Unit Preferred: \_\_\_\_\_

Inpatient CPT Code Present: \_\_\_\_\_

Attending/Admitting Physician: \_\_\_\_\_

Service/Group to be admitted to: \_\_\_\_\_

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

**\*\*NURSING ORDERS may be initiated by RN after assessing patient condition\*\***

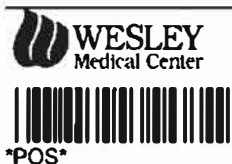
*I certify that the patient status is appropriate and is based on my best clinical judgement and the patient's condition as documented in the medical record*

TORB \_\_\_\_\_ / / \_\_\_\_\_  
RN Signature Date Time

ED Physician/Resident \_\_\_\_\_ / / \_\_\_\_\_  
Physician Provider # Date Time

Physician Signature (Signature Level Provider) \_\_\_\_\_ / / \_\_\_\_\_  
Physician Provider # Date Time

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Patient Identification

MR701 (R07.17)