EVERGREEN
SERVICE PROVIDERS

PHYSICIAN'S ORDERS

PHYSICIAN: ___________________________ DATE: _____________ TIME: _________

INDIVIDUAL: ____

DESCRIPTION OF MEDICAL PROBLEM: ______________________________________

____

ALLERGIES: ____

PERSON MAKING REPORT: ____

PHYSICIAN'S NOTES

SUBJECTIVE: ____

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OBJECTIVE: ____

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ASSESSMENT: ____

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PLAN & ORDERS: ____

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____

PHYSICIAN'S SIGNATURE: ____

DATE: ____

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EvergreenServiceProviders.com