Physician’s Order for Specialized Health Care Procedure(s)

Student’s Name: ______________________________________  D.O. B: _______________________

Address: ____________________________________________________________________________

Street    City    State    Zip

Procedure:

☐ Tube Feeding →

☐ Clean Intermittent Catheterization →

☐ Ostomy Care →

☐ Oxygen Therapy →

☐ Tracheostomy Care →

☐ Tracheal Suctioning →

☐ Nose/Mouth Suctioning →

☐ Ventilation →

☐ Other: →

Recommendations:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Duration of the Procedure: ____________________________________________________________

Physician: _______________________________  Phone: __________________

Office Address: __________________________________________________________

___________________________________________  Date: _____________________

Physician Signature