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