



PPEC ADMISSION ORDERS

Patient Name: _____

DOB: _____ **Allergies:** _____

Diagnoses: _____

MEDICAL HISTORY: _____

SEND REQUIRED IMMUNIZATION FORMS 680-3040

DIET: _____

ACTIVITY: _____

MEDICATIONS / TREATMENTS (INCLUDE PRNs): _____

PRECAUTIONS: _____

ORDER: PPEC MON – FRI UP TO 12 HRS/DAY FOR 180 DAYS, PT, OT AND ST EVALUATE AND

TREATMENT. _____

YES, ABOVE CHILD MAY BE ADMITTED TO PPEC SETTING.

PHYSICIAN SIGNATURE

DATE