Salem-Keizer School District 24J
Student Services
P.O. Box 12024
Salem, OR 97309 -0024
(503) 399-3101

PROVIDER'S REPORT AND TREATMENT ORDERS

CONFIDENTIAL

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED PHYSICAL HEALTH CARE SERVICES

PLEASE FAX TO STUDENT SERVICES AT (503) 316-3500

Student ID: _____ **Student Name:** _____ **DOB:** _____

School Name: _____ **Nurse:** _____ may be reached at (503) 399-3101

Medical Diagnosis: _____

Comments/Updates: _____

FEEDING

☐ NPO ☐ Aspiration risk ☐ Diet: _____
☐ Foods/liquids per Salem-Keizer Feeding and Swallowing Team and/or OT/COTA
☐ Swallow study completed (**see attached for details**)

Comments: _____

PROCEDURE: PROVIDE SPECIFIC PARAMETERS

GASTROSTOMY TUBE

Type: ☐ G-tube Balloon: _____ cc ☐ Nurse may replace if dislodged
☐ G-J tube

☐ Tube feeding: _____
☐ Vent tubing: _____
☐ Volume, rate, frequency, formula type per parent direction via bolus, gravity, or pump
☐ Syringe push

Comments: _____

ORAL SUCTIONING

Indication: _____ Frequency: _____

Comments: _____

PULSE OXIMETERY

Time: _____ ☐ Continuous ☐ Spot checks

Alarm settings: Low SaO2 _____% HR high _____/low _____

Comments: _____

OXYGEN

☐ Continuous at _____ L/min
☐ Start O2 at _____ L/min if SaO2 <_____%
☐ Give _____ L/min to maintain SaO2 > _____%
☐ Can titrate/discontinue O2 if SaO2 maintained at _____% for _____ min

CATHETERIZATION

Type/Size: _____ Frequency: _____

Comments: _____

PHYSICIAN'S SIGNATURE INDICATES APPROVAL OF ABOVE ORDERS AS WRITTEN

Physician's Name (Print): _____ Signature: _____ Date: _____