attach patient label

Physician Orders

LEB Neurology Seizure Admit Plan

[X or R] = will be ordered unless marked out.

PEDIATRIC

Height: _____**cm** **Weight:** _____**kg**

Allergies:		[ ] No known allergies
[ ]	Initiate Powerplan Phase	T;N, Phase: LEB Neuro Seizure Admit Phase
	Admission/Transfer/Discharge	
[ ]	Admit Patient to Dr. _____	
	Admit Status: [ ] Inpatient [ ] Routine Post Procedure <24hrs [ ] 23 hour OBS	
	Bed Type: [ ] Med/Surg [ ] Critical Care [ ] Stepdown [ ] Telemetry; Specific Unit Location: _____	
[ ]	Admit Patient	T;N
[ ]	Notify Physician-Once	T;N, of room number on arrival to unit
Primary Diagnosis:_____		
Secondary Diagnosis: _____		
	Vital Signs	
[ ]	Vital Signs	T;N, Routine Monitor and Record T,P,R,BP
	Activity	
[ ]	Bedrest	T;N
[ ]	Out Of Bed	T;N,Frequency:_____
[ ]	Out Of Bed (Up)	T;N, With Assistance
[ ]	Activity As Tolerated	T;N, Up Ad Lib
	Food/Nutrition	
[ ]	NPO	Start at: T;N
[ ]	Breastfeed	T;N
[ ]	Formula Per Home Routine	T;N
[ ]	**LEB Formula Orders Plan**	**see separate sheet**
[ ]	Regular Pediatric Diet	Start at: T;N
[ ]	Clear Liquid Diet	Start at: T;N
	Patient Care	
[ ]	**LEB Status Eplilepticus Plan**	**see separate sheet**
[ ]	Advance Diet As Tolerated	T;N, Start clear liquids and advance to regular diet as tolerated.
[ ]	Seizure Precautions	T;N
[ ]	Strict I/O	T;N, q2h(std)
[ ]	Daily Weights	T;N, qEve
[ ]	Hepwell Insert/Site Care LEB	T;N, q2h(std)
[ ]	Convert IV to INT/Hepwell	T;N, Heplock IV when patient tolerating PO
[ ]	O2 Sat Spot Check-NSG	T;N, with vital signs
[ ]	Cardiopulmonary Monitor	T;N Routine, Monitor Type: CP Monitor
	Continuous Infusions	
[ ]	D5 1/2 NS KCl 20 mEq/L	1,000mL,IV,Routine,T:N, at____mL/hr
	Medications	
[ ]	Heparin 10 unit/mL flush	5 mL (10units/mL),Ped Injectable, IVPush, prn, PRN Cath Clearance, routine,T;N, peripheral or central line per nursing policy
[ ]	acetaminophen	_____mg(10 mg/kg), Liq, PO, q4h, PRN Pain or Fever, routine,T;N,Max Dose=90mg/kg/day up to 4 g/day
[ ]	acetaminophen	80 mg, chew tab, PO, q4h, PRN Pain or Fever, routine, T;N,Max Dose=90 mg/kg/day up to 4 g/day

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PEDIATRIC

Medications continued		
[ ]	acetaminophen	325mg, tab, PO, q4h, PRN Pain or Fever, routine,T;N,Max Dose=90 mg/kg/day up to 4 g/day
[ ]	acetaminophen	_____mg(10 mg/kg), Supp, PR, q4h, PRN Pain or Fever, routine, T;N,Max Dose=90mg/kg/day up to 4 g/day
[ ]	ibuprofen	_____mg (10mg/kg),Oral Susp,PO,q8h,PRN, pain,T;N, Max dose = 800 mg
[ ]	diazepam	_____mg(0.1mg/kg),injection,IVPush,q6h,PRN, seizure activity,T;N, Max dose = 15 mg
[ ]	diazepam	2.5mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	5mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	7.5mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	10mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	12.5mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	15mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	17.5mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	diazepam	20mg,Gel,PR,q8h,PRN Seizure Activity,routine,T;N
[ ]	**LEB Antiepileptic Medication Orders Plan**	**See separate sheet**
Laboratory		
[ ]	CBC	Routine, T;N, once, Type: Blood
[ ]	Platelet Count	Routine, T;N, once, Type: Blood
[ ]	Basic Metabolic Panel (BMP)	Routine, T;N, once, Type: Blood
[ ]	Hepatic Panel	Routine, T;N, once, Type: Blood
[ ]	**LEB Anticonvulsant Lab Orders Plan**	**see separate sheet**
[ ]	Pregnancy Screen Serum	Routine, T;N, once, Type: Blood
Diagnostic Tests		
[ ]	**MRI Brain & Stem W Cont Plan**	**see separate sheet**
[ ]	EEG	T;N, EEG Type: EEG at Bedside | Wake/Sleep 45min, Reason: Seizures, Routine
[ ]	EEG	T;N, EEG Type: EEG in Lab | Wake/Sleep 45min, Reason: Seizures, Routine
[ ]	**CT Brain Head W Cont Plan**	**see separate sheet**
[ ]	CT Brain/Head WO Cont	T;N, Reason:_____, Routine, Wheelchair
Consults/Notifications		
[ ]	Notify Physician-Continuing	T;N, Who:_____,For: If patient has one generalized tonic-clonic seizure or more than 2 partial seizures in an 8 hour period
[ ]	Notify Resident-Continuing	T;N, Who:_____,For: If patient has one generalized tonic-clonic seizure or more than 2 partial seizures in an 8 hour period
[ ]	Notify Resident-Once	T;N, Who:_____For:_____
[ ]	Consult MD Group	T;N, Consult Who:_____,Reason:_____
[ ]	Consult MD	T;N, Consult Who:_____,Reason:_____
[ ]	Consult Medical Social Work	T;N, Reason:_____

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PEDIATRIC

	Consults/Notifications continued	
[ ]	Dietitian Consult	T;N, Reason:_____
[ ]	Child Life Consult (Consult Child Life)	T;N, Reason:_____
[ ]	PT Ped Eval & Tx (Physical Therapy Ped Eval & Tx)	T;N, Routine,Reason:_____
[ ]	OT Ped Eval & Tx (Occupational Therapy Ped Eval & Tx)	T;N, Routine,Reason:_____
[ ]	ST Ped Eval & Tx (Speech Therapy Ped Eval & Tx)	T;N, Routine,Reason:_____

Date	Time	Physician's Signature	MD Number
_____	_____	_____	_____