Le Bonheur Children's Medical Center

attach patient label

PHYSICIAN ORDERS

Care Set: Pediatric Post-Op Vagus Nerve Stimulator Placement

Date: _________ Time: _________ Weight: ______ kg Height: ______ cm BSA _________

Admission

Admit to Dr. ____________________ [ ] ICU [ ] Neuro ICU Step-Down
Pager: ____________________ [ ] Floor____________________
Status: [ ] Inpatient [ ] Observation
[ ] Notify physician of room number on arrival to unit
Primary Diagnosis: ____________________
Secondary Diagnosis: ____________________
Allergies: [ ] No known allergies [ ] Latex allergy [ ] Other: ____________________
[ ] Medication allergy(s):____________________

Vital Signs

[ ] Vital Signs and neuro checks q 1 hr x 2 hrs, then q 2 hrs x 8 hrs, then q 4 hrs x 48 hrs, then q 8 hrs
[ ] Q 2 hrs
[ ] Q 4hrs
[ ] Routine

Activity

[ ] Bedrest
[ ] Out of bed _______ times per day
[ ] Assist
[ ] As tolerated

Food/Nutrition

[ ] Clear liquids, advance as tolerated
[ ] Regular - age appropriate

Patient Care

[ ] Seizure Precautions
[ ] Elevate Head of Bed
[ ] Record I & O
[ ] Continuous Pulse OX
[ ] CP Monitor
[ ] Notify House Officer of temperature greater than 38.5 degrees Celcius.

Medications (this section can be subdivided as necessary)

[ ] 0.9% NS IV at ______________ ml/hr
[ ] D5 1/4 NS IV at ______________ ml/hr
[ ] D5 1/4 NS IV with 20 mEq KCL/1000ml at ______________ ml/hr
[ ] Heplock IV when tolerating PO well; flush with Heparin 10 units/ml
[ ] Acetaminophen (10-15mg/kg/dose) ________ mg [ ] PO [ ] PR every 4 hours PRN pain/discomfort (max dose 650 mg)
[ ] Acetaminophen with codeine elixir (0.5-1mg/kg codeine per dose) _____ mg PO every 4 hours PRN pain (max. dose 60 mg of codeine) (12.5mg Codeine/5cc)
[ ] Ibuprofen (10mg/kg/dose) ________ mg PO every 6 hours PRN pain/discomfort (max dose 800 mg)
[ ] Ondansetron (0.1mg/kg/dose) ________ mg IV every 8 hours PRN nausea/vomiting (max. dose 4 mg)
[ ] Cefazolin (8-34mg/kg/dose) ________ mg IV every 8 hours x ________ hr (max. dose 6gms/day)
[ ] Vancomycin (10mg/kg/dose) ________ mg IV every 6 hours x ________ hr
[ ] Indication for Vancomycin [ ] Allergy to cephalosporins
[ ] [ ] Treatment for methicillin - resistant S. aureus
[ ] [ ] Other
[ ] Morphine (0.05-0.1mg/kg/dose) ________ mg IV every 3 hours PRN severe pain (max. dose 4 mg)
[ ] Other: ____________________
[ ] Other: ____________________
[ ] Other: ____________________
[ ] Other: ____________________
[ ] Other: ____________________

Diagnostic Tests

[ ] Labs: ____________________
____
____

Consults

[ ]
[ ]
[ ]
[ ]

______________________ ______________________ ______________________ ______________________
Physician's/Nurse Practitioner's Signature | Name Printed | Physician Number | Beeper Number