



attach patient label

Physician Orders: PEDIATRIC

## Title: PED General Medicine Admit Plan

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

Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

**Allergies:** ☐ No known allergies☐ Medication allergy(s): \_\_\_\_\_☐ Latex allergy ☐ Other: \_\_\_\_\_**Uncategorized**☒ Initiate Powerplan Phase T;N, Phase: PED General Medicine Admit Plan**Admission/Transfer/Discharge**☐ Patient Status Initial **Inpatient** Attending Physician: \_\_\_\_\_**Bed Type:** ☐ Med Surg ☐ Telemetry ☐ Critical Care ☐ Stepdown ☐ Obstetrics ☐ Other☐ Patient Status Initial **Outpatient** Attending Physician: \_\_\_\_\_**Outpatient Status/Service:** ☐ OP-Ambulatory ☐ OP-Diagnostic Procedure ☐ OP-Observation Services**NOTE to MD:****Initial status – inpatient** --- For a condition/dx with severity of illness or co-morbid conditions indicating a hospital stay greater than 24 hours is required.**Initial Status Outpatient – Ambulatory surgery** – Outpatient surgery/procedure with discharge anticipated after a routine or, in some cases, extended recovery.

- Routine recovery after outpatient surgery is estimated at 6-8 hours.
- “Extended” routine recovery may be required for a patient to stay longer (could be overnight) to recover from anticipated sequela of surgery including effects of anesthesia, nausea, pain.
- For unanticipated sequela of surgery or a complicated post operative course, the patient may require a status change to inpatient. Please consult with a case manager before making this choice of “status change”.
- Examples: Initial status outpatient is generally selected for patients undergoing PCI, diagnostic caths, EP studies, ablations, pacemaker implantations, other routine surgeries.

**Initial status Outpatient -Observation Services** – Short term treatment, assessment and reassessment - estimate discharge within 24 hours

- In some cases (for Medicare patients), this can be extended to 48 hours.
- Observation Services can also be utilized when it is unclear (without additional assessment) whether the patient will require an inpatient stay.

☐ 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☐ Vital Signs T;N, Monitor and Record T,P,R,BP, q4h(std)**Activity**☐ Out Of Bed ( Activity As Tolerated ) T;N, Up As Tolerated**Food/Nutrition**☐ NPO Start at: T;N☐ Breastfeed T;N, frequency: \_\_\_\_\_☐ Formula Per Home Routine T;N☐ Regular Pediatric Diet Start at: T;N



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Patient Care		
<input type="checkbox"/>	Advance Diet As Tolerated	T;N, start clear liquids and advance to regular diet as tolerated
<input type="checkbox"/>	Isolation Precautions	T;N, Isolation Type: Droplet Precautions
<input type="checkbox"/>	Isolation Precautions	T;N, Isolation Type: Contact Precautions
<input type="checkbox"/>	Isolation Precautions	T;N, Isolation Type: Droplet Precautions, Contact Precautions
<input type="checkbox"/>	Strict I/O	T;N, Routine, q2h(std)
<input type="checkbox"/>	Daily Weights	T;N, Routine, qEve
<input type="checkbox"/>	O2 Sat Spot Check-NSG	T;N, with vital signs
<input type="checkbox"/>	O2 Sat Monitoring NSG	T;N
<input type="checkbox"/>	Cardiopulmonary Monitor	T;N Routine, Monitor Type: CP Monitor
Respiratory Care		
<input type="checkbox"/>	Oxygen Delivery PEDS	T; N, _____L/min, Titrate to keep O2 sat $\geq$ 92%. Wean to room air.
Continuous Infusions		
<input type="checkbox"/>	Sodium Chloride 0.9% Bolus	_____mL, Injection, IV, once, Infuse over 15 min, STAT, T;N
<input type="checkbox"/>	D51/2NS	1000mL, IV, Routine, T;N, at _____mL/hr
<input type="checkbox"/>	D5 1/4 NS	1000mL, IV, Routine, T;N, at _____mL/hr
<input type="checkbox"/>	D5 1/2 NS KCl 20 mEq/L	1000mL, IV, Routine, T;N, at _____mL/hr
<input type="checkbox"/>	D5 1/4 NS KCl 20 mEq/L	1000mL, IV, Routine, T;N, at _____mL/hr
Medications		
<input type="checkbox"/>	acetaminophen	_____mg(10 mg/kg), Liq, PO, q4h, PRN Pain or Fever, T;N, Max Dose=90 mg/kg/day up to 4g/day
<input type="checkbox"/>	acetaminophen	_____mg(10 mg/kg), Supp, PR, q4h, PRN Pain or Fever, T;N, Max Dose=90 mg/kg/day up to 4g/day
<input type="checkbox"/>	acetaminophen	80 mg, chew tab, PO, q4h, PRN Pain or Fever, T;N, Max Dose=90 mg/kg/day up to 4g/day
<input type="checkbox"/>	acetaminophen	325mg, tab, PO, q4h, PRN Pain or Fever, T;N, Max Dose=90 mg/kg/day up to 4g/day
<input type="checkbox"/>	<b>PED Anti-infectives Order Plan</b>	<b>See separate sheet</b>
Laboratory		
<input type="checkbox"/>	CBC	T;N, Routine, once, Type: Blood
<input type="checkbox"/>	CMP	Routine, T;N, once, Type: Blood
<input type="checkbox"/>	Urinalysis	STAT, T;N, once, Type: Urine Catheterized, Nurse Collect
<input type="checkbox"/>	Urinalysis	STAT, T;N, once, Type: Urine, Nurse Collect
<input type="checkbox"/>	Urinalysis w/Reflex Microscopic Exam	STAT, T;N, once, Type: Urine Catheterized, Nurse Collect
<input type="checkbox"/>	Urinalysis w/Reflex Microscopic Exam	STAT, T;N, once, Type: Urine, Nurse Collect
Consults/Notifications		
<input type="checkbox"/>	Physician Group Consult	
<input type="checkbox"/>	Physician Consult	T;N, Consult Who: _____, Reason: _____
<input type="checkbox"/>	Notify Physician-Continuing	T;N, of uncontrolled fever, increased respiratory distress, persistent vomiting, and no urine output for 8 hours.

\_\_\_\_\_  
**Date**                      **Time**                      **Physician's Signature**                      **MD Number**