



Physician Orders

LEB TCU Admit Plan

PEDIATRIC

T= Today; N = Now (date and time ordered)

Height: _____ cm Weight: _____ kg

Allergies: No known allergies

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, Bed Type: Critical Care, Admit to Unit: TCU
- Transfer 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, Monitor and Record T,P,R,BP, q4h(std)
- Vital Signs T;N, Monitor and Record T,P,R,BP

Activity

- Bedrest T;N
- Out Of Bed (Activity As Tolerated) T;N, With Assistance

Food/Nutrition

- NPO Start at: T;N
- Breastmilk (Expressed) T;N
- Formula Per Home Routine T;N
- Formula Orders _____
- Regular Pediatric Diet Start at: T;N
- Clear Liquid Diet Start at: T;N

Patient Care

- Advance Diet As Tolerated T;N, Start clear liquids and advance to regular diet as tolerated.
- Isolation Precautions T;N, Type: _____
- Strict I/O T;N, Routine, intake q1h, output q2h
- Daily Weights T;N, Routine, QDay
- Weight T;N, Routine, per TCU protocol
- Measure Circumference T;N, Of: Head, measure on admission (for ages <1 and as indicated)
- Measure Circumference T;N, Of: Abdominal Girth
- Elevate Head Of Bed T;N, 30 degrees
- Elevate T;N, Area: Affected Extremity
- O2 Sat Monitoring NSG T;N, q4h(std)
- Cardiopulmonary Monitor T;N Routine, Monitor Type: CP Monitor
- Suction Patient T;N, PRN, airway clearance
- Gastrostomy Tube Care T;N, G Tube, use for meds and feedings
- Gastrostomy Tube Care T;N, Suction Strength: To Gravity, G Tube
- NGT T;N, NG Tube Type: Flexible, Use for meds and feedings
- Replogle (NGT) T;N, NG Tube Type: Rigid, Suction Strength: Low Intermittent
- Replogle (NGT) T;N, NG Tube Type: Rigid, Suction Strength: To Gravity
- Replogle (OGT) T;N, OG Tube Type: Rigid, to gravity
- Replogle (OGT) T;N, OG Tube Type: Rigid, Low intermittent wall suction
- Foley Insert T;N, Suction Strength: To Gravity, Drainage



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Respiratory Care		
<input type="checkbox"/>	LEB Critical Care Respiratory Plan	see separate sheet
<input type="checkbox"/>	Initiate Pediatric Respiratory Treatment Protocol	T;N
Continuous Infusions		
<input type="checkbox"/>	Sodium Chloride 0.9% (Sodium Chloride 0.9% Bolus)	_____mL/kg,injection, IV, once, (Infuse over: 15 min), STAT, T;N,(Bolus)
<input type="checkbox"/>	D5 1/2NS	1000mL,IV,Routine,T:N, at _____ mL/hr
<input type="checkbox"/>	D5 1/4NS	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
<input type="checkbox"/>	D10W	1000mL,IV,Routine,T:N, at _____ mL/hr
Medications		
<input type="checkbox"/>	Heparin 10 unit/mL flush	5 mL (10units/mL),Ped Injectable, IVPush, prn, PRN Catheter clearance, routine,T;N, peripheral or central line per nursing policy _____
<input type="checkbox"/>	acetaminophen	_____mg(15 mg/kg), Liq, PO, q4h, PRN Pain or Fever, T;N,Max Dose=90/kg/day up to 4 g/day
<input type="checkbox"/>	acetaminophen	_____mg(15 mg/kg), Supp, PR, q4h, PRN Pain or Fever, T;N,Max Dose=90mg/kg/day up to 4 g/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 4 g/day
<input type="checkbox"/>	acetaminophen	325mg, tab, PO, q4h, PRN Pain or Fever, T;N,Max Dose=90 mg/kg/day up to 4 g/day
<input type="checkbox"/>	ranitidine	_____ mg, (2 mg/kg), Syrup, PO, bid, Routine, T;N, Max dose = 300 mg/day
<input type="checkbox"/>	chloral hydrate	_____ mg, (50 mg/kg), Syrup, PO, q6h, Routine, T;N, Max total dose = 2 grams/day
Anti-infectives		
<input type="checkbox"/>	LEB Anti-Infective Orders	see separate sheet
Laboratory		
<input type="checkbox"/>	LEB Transfusion- 4 Months of Age or Greater Plan	see separate sheet
<input type="checkbox"/>	LEB Transfusion- Neonate Less than 4 Months of Age Plan	see separate sheet
<input type="checkbox"/>	CBC	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Basic Metabolic Panel (BMP)	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Comprehensive Metabolic Panel (CMP)	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	C-Reactive Protein (CRP)	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Prothrombin Time (PT/INR)	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Partial Thromboplastin Time (PTT)	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Fibrinogen Level	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Triglyceride	STAT, T;N, once, Type: Blood
<input type="checkbox"/>	Blood Culture	STAT, T;N, once, Specimen Source: Peripheral Blood
<input type="checkbox"/>	Blood Culture	T;N, STAT, blood,once, Specimen Source: _____
<input type="checkbox"/>	Urinalysis w/Reflex Microscopic Exam	STAT, T;N, once, Type: Urine, Nurse Collect
<input type="checkbox"/>	Urine Culture (Urine C&S)	STAT, T;N, Specimen Source: Urine, Nurse Collect



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Laboratory continued		
<input type="checkbox"/>	Respiratory Culture and Gram Stain	STAT, T;N, Specimen Source: Aspirate Trachea, Nurse Collect
<input type="checkbox"/>	Influenza A/B Antigen (Influenza A&B Screen)	STAT, T;N, once, Type: Nasopharyngeal(N-P), Nurse Collect
<input type="checkbox"/>	RSV Antigen Screen	STAT, T;N, once, Type: NP, Nurse Collect
<input type="checkbox"/>	Respiratory Culture, Viral	STAT, T;N, Specimen Source: Nasopharyngeal(N-P), Nurse Collect
Diagnostic Tests		
<input type="checkbox"/>	Chest 1VW Frontal	T;N, STAT, Reason: _____ Transport:Portable
<input type="checkbox"/>	Abd Sing AP VW (KUB)	T;N, STAT, Reason: _____ Transport:Portable
Consults/Notifications		
<input type="checkbox"/>	Notify Physician For Vital Signs Of	T;N, For: BP Systolic < _____, BP diastolic < _____, mean BP < _____, Celsius Temp < _____, Celsius Temp > _____, HR > _____,HR < _____, Resp Rate > _____, Resp Rate < _____, O2 Sat < _____, UOP < _____, Glucose > _____, Glucose < _____, ICP > _____
<input type="checkbox"/>	Notify Physician-Continuing	T;N, Mental status changes, Increased Oxygen requirements, O2 sats less than _____%, Who: _____
<input type="checkbox"/>	Notify Physician-Continuing	T;N, For: _____, Who: _____
<input type="checkbox"/>	Notify Physician-Once	T;N, For: _____, Who: _____
<input type="checkbox"/>	Notify Nurse Practitioner For Vital Signs Of	T;N, For: BP Systolic < _____, BP diastolic < _____, mean BP < _____, Celsius Temp < _____, Celsius Temp > _____, HR > _____,HR < _____, Resp Rate > _____, Resp Rate < _____, O2 Sat < _____, UOP < _____, Glucose > _____, Glucose < _____, ICP > _____
<input type="checkbox"/>	Notify Nurse Practitioner-Continuing	T;N, Mental status changes, Increased Oxygen requirements, O2 sats less than _____%, Who: _____
<input type="checkbox"/>	Notify Nurse Practitioner-Continuing	T;N, For: _____, Who: _____
<input type="checkbox"/>	Notify Nurse Practitioner-Once	T;N, For: _____, Who: _____
<input type="checkbox"/>	Consult MD Group	T;N, Consult Who: _____, Reason: _____
<input type="checkbox"/>	Consult MD	T;N, Consult Who: _____, Reason: _____
<input type="checkbox"/>	Dietitian Consult	T;N, Type: _____
<input type="checkbox"/>	Lactation Consult	T;N, Reason: _____
<input type="checkbox"/>	Consult Child Life	T;N, Reason: _____
<input type="checkbox"/>	Medical Social Work Consult	T;N, Reason: _____
<input type="checkbox"/>	Physical Therapy Ped Eval & Tx	T;N, Reason: _____
<input type="checkbox"/>	Occupational Therapy Ped Eval & Tx	T;N, Reason: _____
<input type="checkbox"/>	Speech Therapy Ped Eval & Tx	T;N, Reason: _____
<input type="checkbox"/>	Audiology Consult	T;N, Reason: _____
<input type="checkbox"/>	Consult Pastoral Care	T;N, Reason: _____
<input type="checkbox"/>	LCAP Consult	T;N, Reason: _____

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