Physician's/Nurse Practitioner's Signature  ___________________________  Name Printed  ___________________________  Physician Number  ___________________________  Beeper Number  ___________________________

<table>
<thead>
<tr>
<th>Date: _________   Time: _________   Weight: ______ kg   Height: ______ cm   BSA _________</th>
</tr>
</thead>
</table>

**Admission**

Admit to Dr. __________________________________________________

Pager: ______________________________________________________

Status: [ ] 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**

[ ] Q 2 hrs

[ ] Q 4hrs

[ ] Routine

**Activity**

[ ] Bedrest

[ ] Assist

[ ] As tolerated

**Food/Nutrition**

[ ] Regular - age appropriate

**Patient Care**

[ ] Seizure Precautions

[ ] Notify M.D. for any problems.

[ ] Discharge after ____________ hours.

[ ] Follow up with ____________ in office, in ______ weeks.

[ ]

**Medications (this section can be subdivided as necessary)**

[ ] Heparin lock to be inserted and maintained throughout admission; flush with Heparin 10units/ml

[ ] 1% Lidocaine with Epinephrine - 1:100,000 vial to floor for sphenoidal electrode insertion

[ ]