Physician’s Orders
Pediatric Use Only

ADMISSION/TRANSFER ORDERS
STATUS ASTHMATICUS

Date: ___________________ Time: ___________________

Allergies: ______________________________________

Height ________ cm Weight ________ kg ______________________________________________

Admit To: □ Inpt □ Obs Service: ________________________

Attending: ____________________________________

Resident: _____________________________________

Intern: _______________________ Pager _________

Diagnosis: Status Asthmaticus

Other Diagnoses: _________________________________________________________________________________________________________

Assess and Treat According to Asthma Guideline For Inpatients Beginning at Phase 1 2 (circle one)

Vitals: Temperature and Blood Pressure □ per routine □ other

RDAI score and Peak Flow measurements per Asthma Guideline For Inpatients

Diet: □ for age Other (specify)

IVF: □ None □ Heparin well

D5 1/4 NS with 20mEq KCl/L at _______ cc/hr

□ Other (specify)

Medications:

Acute Asthma Treatment:

Phase 1 (q2/per protocol)

☐ Albuterol _____ puffs via MDI
☐ with spacer OR
☐ with spacer and mask
☐ Albuterol ml in 2 ml NS
via nebulization
☐ Ipratropium bromide 0.5 mg
via nebulization

☐ Prednisolone liquid __________________ mg PO BID (1-2 mg/kg/day) (max dose 60 mg/day)
☐ Prednisone tablet __________________ mg PO BID (1-2 mg/kg/day) (max dose 60 mg/day)
☐ Methylprednisolone ______________ mg IV q 6 hours (1 mg/kg/dose) (max dose 80 mg/day)

Controller Asthma Therapy:

☐ Inhaled steroid _____________________ (specify drug name) _____ puffs BID or _____ (other freq)

☐ Pulmicort respules _____ mg via nebulization BID or _____ (other freq)

☐ Montelukast __________ mg PO qhs

☐ Zafirlukast __________ mg PO BID

☐ Nasal steroid __________________ (drug name) _____ puffs with _____ frequency

□ Other (specify)

□ Other (specify)

Oxygen Therapy:

☐ 02 delivered via □ facemask at _______ % or □ nasal cannula at _______ L/min

☐ Wean 02 per Oxygen Therapy Protocol

☐ Intermittent pulse oximetry q _________ hrs.

☐ Continuous pulse oximetry

Equipment:

☐ Spacer device to bedside ☐ Optichamber ☐ Facemask ☐ Inspirease

☐ Peak flow meter to bedside

Consult social work for home pulmoaide

Other Orders:

_________________________ _________________________
Physician Name Printed Physician Signature