Admit/Transfer to Neuroscience Unit

Allergies: ___________________________________________  Weight: _________ kg

Height: ___________ cm

Admit to: ____________________________________________

Admit as: ☐ Inpatient  ☐ Observation  Admit type: ☐ Floor  ☐ Step-down unit

Diagnosis: ___________________________________________

Consult:  ☐ PT  ☐ OT  ☐ ST  ☐ Other (specify) _______________________________________

Diet:  ☐ NPO  ☐ Clear Liquid  ☐ Advance as tolerated  ☐ Regular  ☐ Other (specify) ____________________________

Vital Signs:  ☐ Q1h x 2, then Q2h x 8, then Q4h x 48h, then routine (Q8) and prn

☐ Q2h  ☐ Q4h  ☐ Other: ___________________________________________

Activity:  ☐ Bedrest  ☐ OOB ______ X per day  ☐ As tolerated  ☐ Assist

Intake/Output:  ☐ Yes  ☐ No

Respiratory:  ☐ CP Monitor  ☐ Continuous Pulse Oximeter  ☐ Other: ________________________________

Labs: __________________________________________________

Medications (be sure to include any home medications):
________________________________________________________________________

PRN Medications:

☐ Acetaminophen (10-15mg/kg) _____ mg  ☐ PO  ☐ PR every 4 hours PRN pain/discomfort

☐ Ondansetron (0.1 mg/kg, up to 4 mg) _____ mg  ☐ IV  ☐ IM  ☐ PO every 8 hours PRN nausea/vomiting

☐ Acetaminophen/Hydrocodone (500mg, one tablet if <50kg, two tablets if > 50kg) _____ tablets PO every 4 hours PRN pain

☐ Acetaminophen/Hydrocodone oral solution (0.2 mg/kg Hydrocodone, up to 10 mg) _____ mg every 4 hours PRN pain

☐ Morphine (0.1 mg/kg) ____mg  ☐ IV  ☐ IM every 2 hours PRN pain

☐ Diphenhydramine (1.25 mg/kg, maximum dose: 50 mg) _____mg PO every 6 hours PRN itching

☐ Docusate Sodium (1.25 mg/kg) _____mg PO every 6 hours PRN constipation (Max dose 400 mg/day)

☐ Lidocaine 4% cream (LMX 4) topically PRN before IV starts/procedures

☐ Other: _______________________________________________

IV Fluids:  ☐ D5W 1/2 NS with 20 Meq/L KCL to run at _____ mL/hr

☐ Heplock when taking PO well; flush with heparin 10 units/mL

☐ Other: _______________________________________________

________________________________________________________________________

Physician Signature  ___________________________________________  Physician ID #

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