attach patient label

LeBonheur Children's Medical Center

Physician Orders

LEB NICU PDA Ligation Post Op Plan

PEDIATRIC

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

Height: _____cm Weight: _____kg

Allergies:		[ ] No known allergies
	Vital Signs	
[ ]	Vital Signs	T;N, Monitor and Record T,P,R,BP, q1h X _____h, then q2h, BP all four extremities
	Activity	
[ ]	Out Of Bed (Activity As Tolerated)	T;N, Up Ad Lib
	Food/Nutrition	
[ ]	NPO	Start at: T;N
[ ]	Breastmilk (Expressed)	T;N,_____mL, _____ frequency
[ ]	Breastmilk, Donor	T;N,_____mL, _____ frequency
[ ]	Formula Orders	_____
	Patient Care	
[ ]	Isolation Precautions	T;N, Isolation Type:_____
[ ]	Strict I/O	T;N, Routine, q2h(std)
[ ]	Position Patient	T;N
[ ]	O2 Sat Monitoring NSG	T;N q1h(std)
	Respiratory Care	
[ ]	**NICU Respiratory Plan**	**see separate sheet**
	Continuous Infusions	
	NOTE: Use D5 for Infants less than 1000 grams. Use D10 for Infants greater than 1000 grams.	
[ ]	D5W	1000mL,IV,STAT,T:N, at____mL/hr
[ ]	D10W	1000mL,IV,STAT,T:N, at____mL/hr
[ ]	D12.5W	500mL,IV,STAT,T:N, at____mL/hr
[ ]	D5 1/4 NS	1000mL,IV,STAT,T:N, at____mL/hr
[ ]	D10 1/4 NS	250mL,IV,STAT,T:N, at____mL/hr
[ ]	D5 1/4 NS KCL 20mEq/L	1000mL,IV,STAT,T:N, at____mL/hr
[ ]	D10 1/4 NS KCL 20mEq/L	250mL,IV,STAT,T:N, at____mL/hr
[ ]	D5 1/2 NS KCL 20mEq/L	1000mL,IV,STAT,T:N, at____mL/hr
[ ]	D10 1/2 NS KCL 20mEq/L	250mL,IV,STAT,T:N, at____mL/hr
[ ]	1/2 NS with heparin 1 unit/ml	250mL,IV,STAT,T:N, at____mL/hr,Infuse via central or arterial line
[ ]	Sodium Chloride 0.9% Bolus	mL, IV, once, STAT, (1 dose), (infuse over 30 min), (Bolus)
	Sedatives	
[ ]	morPHINE drip (pediatric)	_____mcg/kg/hr, Injection, IV, routine,T;N, Use most concentrated strengths, Reference range: 10 to 20 mcg/kg/hr
[ ]	fentaNYL drip (pediatric)	_____mcg/kg/hr, Injection, IV, routine,T;N, Use most concentrated strengths, Reference range: 1 to 5 mcg/kg/hr
[ ]	midazolam drip (pediatric)	_____mg/kg/hr, Injection, IV, routine, T;N, Use most concentrated strengths, Reference range: 0.01 to 0.2 mg/kg/hr
	Medications	
[ ]	Heparin 10 unit/mL flush	1 mL (10units/mL),Ped Injectable, IVPush, prn, PRN Cath Clerance, routine,T;N, peripheral or central line per nursing policy
[ ]	acetaminophen	_____mg(15 mg/kg), Supp, PR, q4h, PRN Pain, routine, T;N,Max Dose=90mg/kg/day up to 4 g/day
[ ]	fentaNYL	_____mcg(1mcg/kg), Injection, IV, q3h, PRN Pain,T;N
[ ]	morPHINE	_____mg(0.1mg/kg), Injection, IV, q4h, PRN Pain,T;N

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	Laboratory	
[ ]	CBC	STAT, T;N, once, Type: Blood
[ ]	BMP	STAT, T;N, once, Type: Blood
[ ]	CMP	STAT, T;N, once, Type: Blood
[ ]	CRP	STAT, T;N, once, Type: Blood
[ ]	**LEB Transfusion Less Than 4 Months of Age Plan**	**see separate sheet**
[ ]	**LEB Transfusion-4 Months of Age or Greater Plan**	**see separate sheet**
	Diagnostic Tests	
[ ]	Chest 1VW Frontal (CXR Portable)	T;N, routine, Reason: post PDA Ligation, Transport: Portable
	Consults/Notifications	
[ ]	Notify Physician-Continuing	T;N, Notify: Surgical Team, any post op complications such as hemothorax, pneumothorax, chlothorax or wound problems.
[ ]	Notify Physician-Once	T;N, when CXR is completed and upper/lower extremity BP results
[ ]	Notify Physician For Vital Signs Of	T;N, For: O2 sats less than 85%, Who:_____
[ ]	Notify Physician-Continuing	T;N, For:_____, Who:_____
[ ]	Notify Physician-Once	T;N, For:_____, Who:_____
[ ]	Notify Nurse Practitioner For Vital Signs Of	T;N, For: O2 sats less than 85%, Who:_____
[ ]	Notify Nurse Practitioner-Continuing	T;N, For:_____, Who:_____
[ ]	Notify Nurse Practitioner-Once	T;N, For:_____, Who:_____
[ ]	Consult MD Group	T;N, Consult Who:_____,Reason:_____
[ ]	Consult MD	T;N, Consult Who:_____,Reason:_____
[ ]	PICC Nurse Consult	T;N Stat, Reason for Consult: Insert PICC
[ ]	Nutritional Support Team Consult	Start at: T;N, Priority: Stat, Reason: Parenteral Nutrition Support
[ ]	Dietitian Consult	T;N, Type of Consult: Nutrition Management
[ ]	Lactation Consult	T;N, Reason:_____
[ ]	Consult Child Life	T;N, Reason:_____
[ ]	Physical Therapy Ped Eval & Tx	T;N, Reason:_____
[ ]	Occupational Therapy Ped Eval & Tx	T;N, Reason:_____
[ ]	Speech Therapy Ped Eval & Tx	T;N, Reason:_____
[ ]	Medical Social Work Consult	T;N, Reason: Assistance at Discharge
[ ]	Consult Pastoral Care	T;N, Reason for Consult: Baptism | Family Support

_____ _____ _____ _____

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