

Location: _____

General

Common Present on Admission - Newborn

- ☐ **ABO HDN** Once, Routine
- ☐ **Acute Respiratory Insufficiency** Once, Routine
- ☐ **Acute Respiratory Failure** Once, Routine
- ☐ **Amniotic Fluid Aspiration with Pneumonia** Once, Routine
- ☐ **Alloimmune thrombocytopenia** Once, Routine
- ☐ **Bacterial sepsis of newborn** Once, Routine
- ☐ **Birth injury, unspecified** Once, Routine
- ☐ **Bilious vomiting of newborn** Once, Routine
- ☐ **Cephalhematoma** Once, Routine
- ☐ **Choanal atresia** Once, Routine
- ☐ **Congenital Syphilis** Once, Routine
- ☐ **Cardiac murmur, unsepcified** Once, Routine
- ☐ **Cephalhematoma due to birth injury** Once, Routine
- ☐ **Meningoencephalitis due to HSV Newborn** Once, Routine
- ☐ **Down's Syndrome** Once, Routine
- ☐ **Erb's Palsy** Once, Routine
- ☐ **Subgaleal hemorrhage** Once, Routine
- ☐ **Transient Neonatal Thrombocytopenia** Once, Routine
- ☐ **Infant of diabetic mother** Once, Routine
- ☐ **Fracture of clavicle due to birth injury** Once, Routine
- ☐ **Hypermagnesemia** Once, Routine
- ☐ **Hyperglycemia** Once, Routine
- ☐ **Feeding problems** Once, Routine
- ☐ **Metabolic acidosis** Once, Routine
- ☐ **Meconium Aspiration Pneumonia** Once, Routine
- ☐ **Prematurity** Once, Routine
- ☐ **Transient tachypnea of newborn** Once, Routine
- ☐ **Thrombocytopenia due to platelet alloimmunization** Once, Routine
- ☐ **Rh isoimmunization in newborn** Once, Routine
- ☐ **Other hemolytic diseases of newborn** Once, Routine
- ☐ **HIE (hypoxic-ischemic encephalopathy), mild** Once, Routine
- ☐ **HIE (hypoxic-ischemic encephalopathy), moderate** Once, Routine
- ☐ **HIE (hypoxic-ischemic encephalopathy), severe** Once, Routine
- ☐ **HIE (hypoxic-ischemic encephalopathy), severe** Once, Routine
- ☐ **IUGR (intrauterine growth retardation) of newborn** Once, Routine
- ☐ **Exceptionally large newborn baby** Once, Routine
- ☐ **Other heavy for gestational age newborn** Once, Routine
- ☐ **Post-term infant with 40-42 completed weeks of gestation** Once, Routine
- ☐ **PPHN (persistent pulmonary hypertension)** Once, Routine
- ☐ **Respiratory depression of newborn** Once, Routine

Sign: _____ Printed Name: _____ Date _____

- ☐ **Sepsis** Once, Routine
- ☐ **Stridor** Once, Routine
- ☐ **Pneumothorax** Once, Routine
- ☐ **Newborn suspected to be affected by chorioamnionitis** Once, Routine
- ☐ **Syphilis, congenital** Once, Routine
- ☐ **HSV infection** Once, Routine
- ☐ **Respiratory Distress Syndrome** Once, Routine
- ☐ **No prenatal care in current pregnancy, unspecified trimester** Once, Routine
- ☐ **Neonatal abstinence syndrome** Once, Routine
- ☐ **Vomiting of newborn-Other** Once, Routine

Admission Order (Required)

- ☒ **Admit to inpatient** Once, Routine

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Admitting Physician:

Level of Care:

Patient Condition:

Bed request comments:

Code Status

@CERMSGREFRESHOPT(674511:21703,,,1)@

- ☒ **Code Status**

DNR and Modified Code orders should be placed by the responsible physician.

- ☐ **Full code** Continuous, Routine

Code Status decision reached by:

- ☐ **DNR (Do Not Resuscitate)** (Required)

- ☒ **DNR (Do Not Resuscitate)** Continuous, Routine

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

Code Status decision reached by:

- ☐ **Consult to Palliative Care Service**

- ☒ **Consult to Palliative Care Service** Once, Routine

Priority:

Reason for Consult?

Order?

Name of referring provider:

Enter call back number:

Reason for Consult?

- ☐ **Consult to Social Work** Once, Routine

Reason for Consult:

Reason for Consult?

- ☐ **Modified Code** Continuous, Routine

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

Modified Code restrictions:

Code Status decision reached by:

- ☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** Continuous - Treatment Restrictions, Routine

I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided.:

Treatment Restriction decision reached by:

Specify Treatment Restrictions:

Code Status decision reached by:

Sign: _____ Printed Name: _____ Date _____

Isolation

- ☐ **Airborne isolation status**
- ☒ **Airborne isolation status** Continuous, Routine
- ☐ **Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics.**
Once, Routine
- ☐ **Contact isolation status** Continuous, Routine
- ☐ **Droplet isolation status** Continuous, Routine
- ☐ **Enteric isolation status** Continuous, Routine

Precautions

- ☐ **Latex precautions** Continuous, Routine
- ☐ **Seizure precautions** Continuous, Routine
Increased observation level needed:

Nursing

Vital Signs

- ☒ **Cardio respiratory monitoring** Continuous, Routine
Low Heart Rate Alarm? 100
High Heart Rate Alarm? 200
Keep Oxygen Saturation (or low limit) Greater than Equal to (%)? 90
High Heart Rate Alarm? 95
- ☒ **Vital signs - T/P/R** Every 3 hours, Routine
- ☒ **Pulse oximetry** Continuous, Routine
Current FIO2 or Room Air:
- ☐ **BP check on four limbs** Once, Routine
Specify location: ☐ Four limbs
- ☒ **Measure blood pressure** Routine

Nursing - General

- ☒ **Gestational assessment** Once, Routine, To be completed during transition.
- ☒ **Cord care** Per unit protocol, Routine
Care:
- ☒ **Notify Physician if maternal temperature is greater than 101.0 or ROM greater than 18 hours** Until discontinued, Routine
- ☒ **Bedside glucose** As directed, Routine, Blood, For babies requiring IV Fluids on admission, check bedside glucose on admission. If Bedside Glucose is less than 40, draw serum glucose and notify physician.
- ☒ **Strict intake and output (specify)** Every hour, Routine

Activity

- ☐ **Radiant warmer with Servo Control** Once, Routine, Temperature setting at 36.2 - 36.5 degrees Celsius
Servo Control: 36.5
- ☐ **Incubator Manual Control** Once, -1, Occurrences, S, Routine
Servo Control: 36.5
- ☐ **Incubator Servo Control** Once, -1, Occurrences, S, Routine, Temperature settings at 36.2-36.5 Celsius
Servo Control: 36.5

Assessments

- ☒ **Daily weights** Daily, Routine
- ☒ **Frontal occipital circumference** Weekly, Routine
- ☒ **Measure length** Weekly, Routine
- ☐ **Measure abdominal girth** Once, 1, Occurrences, Routine, If distended obtain measurements
- ☒ **Gestational assessment** Once, Routine

Sign: _____ Printed Name: _____ Date _____

☒ **Neonatal BiliTool** Once, Routine, -If baby is at least 35 weeks gestational age and at least 18 hours of life, enter bilirubin level on BiliTool and record risk level (Click reference link below, or go to www.bilitool.org). -If bilirubin level is in a high risk zone, follow recommended Hyperbilirubinemia Protocol for your site. Include immediate physician notification if baby is Coomb's positive. -If bilirubin level is in a high intermediate risk zone, notify physician/physician team during morning rounds. -If baby is at least 35 weeks gestational age and at least 18 hours of life, enter bilirubin level on BiliTool and record risk level (Click reference link below, or go to www.bilitool.org).

-If bilirubin level is in a high risk zone, follow recommended Hyperbilirubinemia Protocol for your site. Include immediate physician notification if baby is Coomb's positive.

-If bilirubin level is in a high intermediate risk zone, notify physician/physician team during morning rounds.

☒ **Congenital Cyanotic Heart Disease screen** Until discontinued, Routine, -First screen after 24 hours of age. Conduct when infant is awake and calm. -Second screen: Perform on every baby admitted to NICU and prior to home discharge. NOTE: Second CCHD unnecessary if baby has had an echocardiogram in the interval before discharge. -Perform in right hand, RH (pre ductal) and one foot (post ductal), in parallel or one after the other. If GREATER than or EQUAL to 95% in RH or foot AND LESS than or EQUAL to 3% difference between RH and foot, PASSED screen. If LESS than 90% in RH or foot: FAILED screen, then notify MD. If 90 - 94% in both RH and foot OR GREATER than 3% difference between RH and foot: REPEAT in 1 hr up to 2 times, then notify MD.

☐ **Neonatal Abstinence Scoring** Once, Routine, Inform physician or physician team for any score 12 or higher OR, total abstinence score is 8 or higher.

Inform physician or physician team for any score 12 or higher OR, total abstinence score is 8 or higher.

HYPOglycemia Management for Newborns

☐ **HYPOglycemia Management for Newborns**

☐ **Implement Intravenous (IV) HYPOglycemia Management for Newborns** Until discontinued, Routine, Click the reference links for algorithms and orders

☒ **Implement ORAL HYPOglycemia Management for Newborns** Until discontinued, Routine, Click the reference links for algorithms and orders

☒ **Bedside glucose** Conditional Frequency, -1, Occurrences, Routine, Blood, As needed per HYPOglycemia Management for Newborns

☒ **Glucose level** Conditional Frequency, 4, Weeks, Routine, Blood, 3, As needed per HYPOglycemia Management for Newborns

☒ **Notify MD/NNP immediately for any of the following for Infant less than 4 hours of age:** Until discontinued, Routine, Any glucose screen less than 25 mg/dl OR any glucose screen less than or equal to 40 mg/dl if infant has already received 2 doses of the dextrose gel since birth.

☒ **Notify MD/NNP immediately for any of the following for Infant 4 to 24 hours of age:** Until discontinued, Routine, Any glucose screen less than 35 mg/dl OR any glucose screen less than or equal to 45 mg/d, if infant has already received 2 doses of glucose gel since birth.

☒ **Notify Physician Neo/Pedi team per HYPOglycemia Management for Newborns** Until discontinued, Routine, Signs of hypoglycemia are non-specific but may include: tachypnea, apnea, respiratory distress, jitteriness, tremors, seizures, temperature instability, irritability, feeding difficulty, lethargy, hypotonia, diaphoresis, cyanosis, etc.

☐ **Insert peripheral IV - As needed per HYPOglycemia Management for Newborns** Once, Routine, As needed per HYPOglycemia Management for Newborns

☐ **dextrose 10% (D10W) IV bolus 2 mL/kg** 2 mL/kg, intravenous, PRN, per HYPOglycemia Management for Newborns

☐ **dextrose (SWEET CHEEKS) gel 40% (neo)** 200 mg/kg, buccal, PRN, asymptomatic hypoglycemia
Do not use beyond 24 hours of age.

Tube Care

☒ **Insert and Maintain Gastric tube** Until discontinued, Routine

Tube Type:

Diet

Sign: _____ Printed Name: _____ Date _____

☐ **Bottle or breast feed** Until discontinued, Routine, Feed when stable

Route:

Infant nutrition # 1:

Infant nutrition # 2:

Infant nutrition # 3:

Breast feed frequency:

Bottle feed frequency:

Fortifier # 1:

Fortifier # 2:

Special instructions:

Total calories/oz:

Volume minimum (mLs):

Volume maximum (mLs):

Volume per feed (mLs):

Ad lib minimum volume (mLs):

Total enteral volume per day (mLs):

Total volume per day (mLs):

Gavage times per day:

Oral times per day:

☐ **NPO** Diet effective now, Routine

NPO:

Pre-Operative fasting options:

☒ **Breast Milk Labels - DO NOT DISCONTINUE** 1, PRN

This order is used to provide patient-specific labels for expressed breast milk. Do not discontinue this order.

Notify

☒ **Notify Physician or Nurse Practitioner immediately IF initial Phototherapy threshold minus TcB/TsB is less than 2 mg/dL OR at or above threshold at any age** Until discontinued, Routine, immediately IF initial Phototherapy threshold minus TcB/TsB is less than 2 mg/dL OR at or above threshold at any age

☒ **Notify Physician or Nurse Practitioner at the nearest hour of testing between 7 a.m.-10 p.m. for any Phototherapy threshold minus TcB/TsB of 2-3.4 mg/dL** Until discontinued, Routine, at the nearest hour of testing between 7 a.m.-10 p.m. for any Phototherapy threshold minus TcB/TsB of 2-3.4 mg/dL

☒ **Notify Physician for prolonged ruptured membranes over 18 hours** Until discontinued, Routine, prolonged ruptured membranes over 18 hours

☒ **Notify Physician infant cord blood pH less than 7.0 or HCO₃ less than 10.0, or BE greater than 15.0** Until discontinued, Routine, infant cord blood pH less than 7.0 or HCO₃ less than 10.0, or BE greater than 15.0

☒ **Notify Physician for any abnormal CBC and differential and/or positive blood culture at 24 and 48 hours** Until discontinued, 48, Hours, Routine, for any abnormal CBC and differential and/or positive blood culture at 24 and 48 hours

IV Fluids

Peripheral IV Access

☐ **Insert and maintain IV access**

☒ **Insert peripheral IV** Once, Routine

☐ **sodium chloride 0.9% flush** 2 mL, intra-catheter, PRN, line care

IV Fluids

☐ **dextrose 10% (D10W) 2 mL/kg IV bolus** 2 mL/kg, intravenous, once, 1, Occurrences

☒ **dextrose 10 % infusion** 10, intravenous, continuous

☐ **dextrose 5% infusion** 5, intravenous, continuous, 99999, Days

IV Fluids (UAC) - NOT HMSL, HMWB, HMTW, HMW, HMCY

☒ **HEParin, porcine (PF) 1 Units/mL in sodium chloride 0.9% 50 mL** intra-arterial, continuous, STAT

Administer via UAC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intra-arterial, continuous, STAT

Administer via UAC

IV Fluids (UAC) - HMSL, HMWB Only

☒ **HEParin (PF) 50 units/50 mL in 0.45% sodium chloride (neo/ped)** 50 UNIT/50 ML, intra-arterial, continuous

Administer via UAC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intra-arterial, continuous, STAT

Administer via UAC

Sign: _____ Printed Name: _____ Date _____

IV Fluids (UAC) - HMTW Only

☐ **HEParin(porcine) in 0.45% NaCl 100 unit/100 mL (1 unit/mL) parenteral solution** intra-arterial, continuous, STAT
Administer via UAC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intra-arterial, continuous, STAT
Administer via UAC

IV Fluids (UAC) - HMW Only

☒ **HEParin, porcine (PF) 1 unit/mL injection in 0.9% Sodium Chloride** 1 , intra-arterial, continuous
Administer via UAC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intra-arterial, continuous, STAT
Administer via UAC

IV Fluids (UAC) - HMCY Only

☐ **HEParin(porcine) in 0.45% NaCl 100 unit/100 mL (1 unit/mL) parenteral solution** intra-arterial, continuous, STAT
Administer via UAC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intra-arterial, continuous, STAT
Administer via UAC

IV Fluids (UVC) - NOT HMSL, HMWB, HMTW, HMW, HMCY

☒ **HEParin, porcine (PF) 1 Units/mL in sodium chloride 0.9% 50 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 5% 250 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 10% 250 mL** intravenous, continuous, STAT
Administer via UVC

IV Fluids (UVC) - HMSL, HMWB Only

☒ **HEParin (PF) 50 units/50 mL in 0.45% sodium chloride (neo/ped) 50 UNIT/50 ML** , intravenous, continuous
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 5% 250 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 10% 250 mL** intravenous, continuous, STAT
Administer via UVC

IV Fluids (UVC) - HMTW Only

☐ **HEParin(porcine) in 0.45% NaCl 100 unit/100 mL (1 unit/mL) parenteral solution** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 5% 250 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 10% 250 mL** intravenous, continuous, STAT
Administer via UVC

IV Fluids (UVC) - HMW Only

☒ **HEParin, porcine (PF) 1 unit/mL injection in 0.9% Sodium Chloride** 1 , intravenous, continuous
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 5% 250 mL** intravenous, continuous, STAT
Administer via UVC

☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 10% 250 mL** intravenous, continuous, STAT
Administer via UVC

IV Fluids (UVC) - HMCY Only

Sign: _____ Printed Name: _____ Date _____

- ☐ **HEParin(porcine) in 0.45% NaCl 100 unit/100 mL (1 unit/mL) parenteral solution** intravenous, continuous, STAT
Administer via UVC
- ☐ **HEParin, porcine (PF) 1 Units/mL, sodium acetate 3.85 mEq in sterile water (PF) 50 mL** intravenous, continuous, STAT
Administer via UVC
- ☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 5% 250 mL** intravenous, continuous, STAT
Administer via UVC
- ☐ **HEParin, porcine (PF) 1 Units/mL in dextrose 10% 250 mL** intravenous, continuous, STAT
Administer via UVC

Neonatal Standard Starter TPN (HMTW Only)

- ☐ **HM IP MEDICATIONS NEONATAL PERIPHERAL STANDARD STARTER TPN (HMW)**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

- ☐ **Neonatal Premix Starter TPN (AA3% D5W Calcium 0.75 mmol/100 mL Heparin 0.5 Unit/mL) infusion 3 %-5 %-**, intravenous, continuous, 24, Hours, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

- ☐ **Neonatal Premix Starter TPN (AA3% D10W Calcium 0.75 mmol/100 mL Heparin 0.5 Unit/mL) infusion 3 %-10 %-**, intravenous, continuous, 24, Hours, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 25 g, Calcium gluconate: 3.75 meq, Heparin: 125 units

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMSL Only)

- ☐ **Neonatal Standard Starter TPN (AA 3% D10W No Additives) 250**, intravenous, continuous, Routine, 250.000 mL

Indication:

Use a 0.2 or 0.22 micron filter.

- ☐ **Neonatal Premix Starter TPN AA3% D10W Calcium gluconate 0.75 mmol/100 mL Heparin 0.5 Units/mL 3 %-10 %-**, intravenous, continuous, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 25 g, Calcium gluconate: 3.75 meq, Heparin: 125 units

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMH, HMSTC Only)

- ☐ **Peripheral Standard Starter**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

- ☐ **D5% Neonatal Standard Starter TPN** intravenous, continuous, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

- ☐ **D10% Neonatal Standard Starter TPN** intravenous, continuous, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMB Only)

- ☐ **Peripheral Standard Starter**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

- ☐ **D5% Neonatal Standard Starter TPN** intravenous, continuous, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

- ☐ **D10% Neonatal Standard Starter TPN** intravenous, continuous, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMWB Only)

- ☐ **Peripheral TPN (HMWB Only)**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

Sign: _____ Printed Name: _____ Date _____

- ☐ **D5% Neonatal Standard Starter TPN 3 %-5** , intravenous, continuous, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 12.5 g, Calcium: 3 mmol, Heparin: 250 units

Use a 0.2 or 0.22 micron filter.

- ☐ **D10% Neonatal Standard Starter TPN 3 %-10 %-** , intravenous, continuous, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 25 g , Calcium gluconate: 3.75 meq, Heparin: 125 units

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMW Only)

- ☐ **HM IP MEDICATIONS NEONATAL PERIPHERAL STANDARD STARTER TPN (HMW)**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

- ☐ **Neonatal Premix Starter TPN (AA3% D5W Calcium 0.75 mmol/100 mL Heparin 0.5 Unit/mL) infusion 3 %-5 %-** , intravenous, continuous, 24, Hours, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

- ☐ **Neonatal Premix Starter TPN (AA3% D10W Calcium 0.75 mmol/100 mL Heparin 0.5 Unit/mL) infusion 3 %-10 %-** , intravenous, continuous, 24, Hours, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 25 g , Calcium gluconate: 3.75 meq, Heparin: 125 units

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMCL Only)

- ☐ **Neonatal Premix Starter TPN AA3% D10W Calcium 3mM Heparin 1 Units/mL 3 %-10 %-** , intravenous, continuous, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

Neonatal Standard Starter TPN (HMCY)

- ☐ **Neonatal Standard Starter TPN**

Standard Starter TPN - For immediate use. Contains no MTE, MVI, or cysteine. No changes made to Standard Starter

- ☐ **Neonatal Premix Starter TPN AA3% D10W Calcium gluconate 0.75 mmol/100 mL Heparin 0.5 Units/mL infusion 3 %-10 %-** , intravenous, continuous, 24, Hours, STAT

Indication:

Each 250 mL bag contains Amino acids: 7.5 g, Dextrose: 25 g , Calcium gluconate: 3.75 meq, Heparin: 125 units

Use a 0.2 or 0.22 micron filter.

- ☐ **Neonatal Premix Starter TPN AA3% D5W Calcium gluconate 0.75 mmol/100 mL Heparin 0.5 Unit/mL infusion 3 %-5 %-** , intravenous, continuous, 24, Hours, STAT

Indication:

Use a 0.2 or 0.22 micron filter.

Lipids (HMH, HMSTC Only)

- ☐ **neonatal fat emulsion 20% (INTRALIPID,LIPOSYN) infusion 20** , intravenous, Continuous TPN at 1500, 24, Hours, STAT, 24.000 Hours

Use a 1.2 micron filter.

Lipids (HMSL, HMTW Only)

- ☐ **neonatal fat emulsion 20% (INTRALIPID,LIPOSYN) infusion 20** , intravenous, Continuous TPN at 2100, 24, Hours, STAT, 24.000 Hours

Use a 1.2 micron filter.

Lipids (HMWB only)

- ☐ **neonatal fat emulsion 20% (INTRALIPID,LIPOSYN) infusion 20** , intravenous, Continuous TPN at 1500, 24, Hours, STAT, 24.000 Hours

Use a 1.2 micron filter.

Lipids (HMW, HMSJ, HMSTJ ONLY)

- ☐ **neonatal fat emulsion 20% (INTRALIPID,LIPOSYN) infusion 20** , intravenous, Continuous TPN at 2000, 24, Hours, STAT, 24.000 Hours

Use a 1.2 micron filter.

Lipids (HMCY)

Sign: _____ Printed Name: _____ Date _____

- ☐ **neonatal fat emulsion 20% (INTRALIPID, LIPOSYN) infusion** 20 , intravenous, Continuous TPN at 2100, 24, Hours, STAT, 24.000 Hours
Use a 1.2 micron filter.
- ☐ **neonatal fat emulsion-MCT-olive-soy-fish (SMOFlipid) 20 % infusion syringe** intravenous, Continuous TPN at 2100, 24, Hours, STAT, 24.000 Hours
Use a 1.2 micron filter.

Medications**Medications**

- ☐ **Birth Weight GREATER than 1500 grams - phytonadione (AQUA-Mephyton) pediatric injection 1 mg** 1 mg, intramuscular, once, 1, Occurrences
- ☐ **Birth Weight LESS than 1500 grams - phytonadione (AQUA-Mephyton) pediatric injection 0.5 mg** 0.5 mg, intramuscular, once, 1, Occurrences
- ☒ **erythromycin 0.5% (ILOTYCIN) ophthalmic ointment** 1 Application, Both Eyes, once, 1, Occurrences, STAT
- ☐ **HM IP MED - HEPATITIS B IMMUNIZATION NEONATES**
- ☐ **HBsAg-Negative Mothers (for infants with birthweight greater than 2000 grams)**
- ☒ **hepatitis B (ENGRIX-B) 10 mcg/0.5 mL vaccine** 10 mcg, intramuscular, once, 1, Occurrences
Administer within 24 hours of birth** REQUIRES CONSENT TO BE OBTAINED PRIOR TO ADMINISTRATION **
- ☐ **HBsAg-Positive Mothers (for term or preterm infants)**
- ☒ **hepatitis B (ENGRIX-B) 10 mcg/0.5 mL vaccine** 10 mcg, intramuscular, once, 1, Occurrences
Administer within 12 hours of birth.** REQUIRES CONSENT TO BE OBTAINED PRIOR TO ADMINISTRATION **
- ☒ **hepatitis B immune globulin (HYPERHEP B NEONATAL) injection** 0.5 mL, intramuscular, once, 1, Occurrences
Give concurrently with hepatitis B (ENGRIX-B) vaccine, but at a different injection site.
RN: Please document the following on the MAR- Lot number, manufacturer and expiration date per health department requirement. VIS is not required for this medication.
- ☐ **HBsAg-Unknown Mothers (for infants with birth weight greater than 2000 grams)**
- ☒ **hepatitis B (ENGRIX-B) 10 mcg/0.5 mL vaccine** 10 mcg, intramuscular, once, 1, Occurrences
Administer within 12 hours of birth.** REQUIRES CONSENT TO BE OBTAINED PRIOR TO ADMINISTRATION **
- ☐ **hepatitis B immune globulin (HYPERHEP B NEONATAL) injection** 0.5 mL, intramuscular, once PRN
Administer as soon as mother is found to be positive or within 7 days of birth.
RN: Please document the following on the MAR- Lot number, manufacturer and expiration date per health department requirement. VIS is not required for this medication.
- ☐ **poractant alfa (CUROSURF) injection** 2.5 mL/kg, intratracheal, once, 1, Occurrences, STAT
- ☐ **zinc oxide-cod liver oil (DESITIN) 40 % paste** 40 , Topical
Specify Site: ***

Antibiotics

Refer to the Pediatric Baylor College of Medicine dosing nomograms when applicable.

- ☐ **ampicillin IV** 100 mg/kg, intravenous, every 8 hours, STAT, 15.000 Minutes
Indication: ○ Bloodstream
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Refer to Baylor College of Medicine dosing nomograms for any dose adjustments.
- ☐ **Gentamicin**
- ☐ **Initial Gentamicin Dosing (Gestational Age LESS than 30 weeks)**
- ☐ **Postnatal Age LESS than or EQUAL to 14 days - gentamicin 5 mg/kg IV every 48 hours** 5 mg/kg, intravenous, every 48 hours, STAT
- ☐ **Postnatal age GREATER than 14 days - gentamicin 5 mg/kg IV every 36 hours** 5 mg/kg, intravenous, every 36 hours, STAT
- ☐ **Initial Gentamicin Dosing (Gestational Age 30 to 34 weeks)**
- ☐ **Postnatal Age LESS than or EQUAL to 14 days - gentamicin 5 mg/kg IV every 36 hours** 5 mg/kg, intravenous, every 36 hours, STAT
- ☐ **Postnatal Age GREATER than 14 days - gentamicin 5 mg/kg IV every 24 hours** 5 mg/kg, intravenous, every 24 hours, STAT
- ☐ **Initial Gentamicin Dosing (Gestational Age 35 to 43 weeks)**

Sign: _____ Printed Name: _____ Date _____

- ☐ **Postnatal Age LESS than or EQUAL to 7 days - gentamicin 4 mg/kg IV every 24 hours** 4 mg/kg, intravenous, every 24 hours, STAT
- ☐ **Postnatal Age GREATER than 7 days - gentamicin 5 mg/kg IV every 24 hours** 5 mg/kg, intravenous, every 24 hours, STAT
- ☐ **Initial Gentamicin Dosing (Gestational Age GREATER than or EQUAL to 44 weeks)**
 - ☐ **Postnatal Age (ALL) - gentamicin 2.5 mg/kg IV every 8 hours** 2.5 mg/kg, intravenous, every 8 hours, STAT

☐ **amikacin IV**

- ☐ **Initial Amikacin Dosing (Gestational Age LESS than 30 weeks)**
 - ☐ **Postnatal Age LESS than or EQUAL to 14 days - amikacin 15 mg/kg IV every 48 hours** 15 mg/kg, intravenous, every 48 hours, STAT
Indication: Bloodstream
 - ☐ **Postnatal Age GREATER than 14 days - amikacin 15 mg/kg IV every 24 hours** 15 mg/kg, intravenous, every 24 hours, STAT
Indication: Bloodstream
- ☐ **Initial Amikacin Dosing (Gestational Age 30 to 34 weeks)**
 - ☐ **Postnatal Age LESS than or EQUAL to 60 days - amikacin 15 mg/kg IV every 24 hours** 15 mg/kg, intravenous, every 24 hours, STAT
Indication: Bloodstream
- ☐ **Initial Amikacin Dosing (Gestational Age 35 to 43 weeks)**
 - ☐ **Postnatal Age LESS than or EQUAL to 7 days - amikacin 15 mg/kg IV every 24 hours** 15 mg/kg, intravenous, every 24 hours, STAT
Indication: Bloodstream
 - ☐ **Postnatal Age GREATER than 7 days - amikacin 17.5 mg/kg IV every 24 hours** 17.5 mg/kg, intravenous, every 24 hours, STAT
Indication: Bloodstream
- ☐ **Initial Amikacin Dosing (Gestational Age greater than or equal to 44 weeks)**
 - ☐ **amikacin 5 mg/kg IV every 8 hours** 5 mg/kg, intravenous, every 8 hours, STAT
Indication: Bloodstream
 - ☐ **amikacin 7.5 mg/kg IV every 8 hours** 7.5 mg/kg, intravenous, every 8 hours, STAT
Indication: Bloodstream

HM RX NEONATAL VASOACTIVE INFUSIONS - NICU ADMISSION☐ **DOBUtamine (DOBUTREX) Infusion**

- ☐ **DOBUtamine (DOBUTREX) infusion in D5W** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?
- ☐ **DOBUtamine (DOBUTREX) infusion in NS** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?

☐ **DOPamine (INTROPIN) Infusion**

- ☒ **DOPamine (INTROPIN) in D5W infusion (Neonatal)** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?

☐ **EPINEPHrine (ADRENALIN) Infusions**

- ☐ **epINEPHrine (ADRENALIN) infusion in D5W** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?
- ☐ **epINEPHrine (ADRENALIN) infusion in NS** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?

☐ **vasopressin (VASOSTRICT) Infusion**

Sign: _____ Printed Name: _____ Date _____

☐ **vasopressin (VASOSTRICT) infusion in D5W (Neonatal)** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?

☐ **vasopressin (VASOSTRICT) infusion in NS (Neonatal)** intravenous, continuous, STAT
IV PUMP requires a rate of GREATER than or EQUAL to 0.1 ml/hr for a 50 mL syringe. Is the ordered rate GREATER than or EQUAL to 0.1 ml/hr?

Medications - PRN

☐ **vitamin A and D ointment** 1 Application, Topical, PRN, with diaper changes

☒ **Sucrose 24 % (Toot-Sweet)**

☐ **sucrose 24 % oral solution (for infants under 1000g, under 28 weeks gestational age, or NPO without NEC evidence)** 0.1 mL, oral, PRN, Procedures

Do not use more than 3 doses during a single procedure. Do not exceed 9 doses in 24 hours.

After sucrose is administered, a pacifier should be offered as a secondary source of analgesia/pacification.

☐ **sucrose 24 % oral solution** 0.2 mL, oral, PRN, Procedures

Do not use more than 3 doses during a single procedure. Do not exceed 9 doses in 24 hours.

After sucrose is administered, a pacifier should be offered as a secondary source of analgesia/pacification.

☐ **zinc oxide-cod liver oil (DESITIN) 40 % paste** 1 Application, Topical, PRN, diaper changes (for diaper rash)
Specify Site: ***

☐ **sodium chloride 0.9 % nasal solution** 2 drop, nasal, 4 times daily PRN, congestion

VTE**Labs****Lab All Babies**

☒ **NBS newborn screen** Once, 1, Occurrences, Routine, Blood, 3, Complete between 24 and 48 hours of life

This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☒ **NBS newborn screen** Conditional Frequency, 1, Occurrences, S, S+15, Routine, Blood, 3, On day of life 10-14, or earlier if requested by physician

This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☒ **Bilirubin, neonatal** Once, Routine, Blood, 3, With first newborn screen

☒ **Cord blood evaluation** Once, Routine, Blood, Test includes ABO and Rh type. Direct Coombs with anti-IgG reagent only.

☒ **Glucose** Conditional Frequency, 4, Weeks, Routine, Blood, 3, If bedside glucose is LESS than 40 milligrams per deciliter

☐ **CBC with differential** Once, Routine, Blood, 3

☐ **CBC with manual differential** Once, Routine, Blood, 3

☐ **Blood culture, aerobic** Once, Routine, Blood, Confirm blood culture results after 24 hours

☐ **Blood gas, arterial** Once, Routine, Blood, 3

☐ **Capillary blood gas** Conditional Frequency, 1, Occurrences, S, Routine, Blood, 3, If unable to obtain arterial blood gas

☐ **Blood gas, venous** Conditional Frequency, 1, Occurrences, S, Routine, Blood, 3, If unable to obtain arterial blood gas.

☐ **Magnesium** Once, Routine, Blood, 3

☐ **Urine drugs of abuse screen** Once, Routine, Urine

☐ **Drug of abuse, meconium** Conditional Frequency, 1, Occurrences, S, S+7, Routine, Meconium, One activation for infants of mothers with unknown prenatal care if mother's toxicology results are unknown or positive. Obtain meconium if available for toxicology screen.

This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☐ **Congenital syphilis test (RPR+TP-PA)** Once, Routine, Blood, 3
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **HSV viral culture TCH** Once, Routine, 3

This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

Rh negative or type O or antibody positive screen mother

☐ **Direct antiglobulin test (DAT) with reflex to anti-complement and anti-IgG** Once, Routine, Blood

Sign: _____ Printed Name: _____ Date _____

Positive Coombs

- ☒ **Hemoglobin & hematocrit** Conditional Frequency, 1, Occurrences, S, S+7, Routine, Blood, 3, For positive Coombs
- ☒ **Reticulocyte count** Conditional Frequency, 1, Occurrences, S, S+7, Routine, Blood, 3, For positive Coombs
- ☒ **Bilirubin, neonatal** Conditional Frequency, 1, Occurrences, S, S+7, Routine, Blood, 3, For positive Coombs

Early Onset Sepsis (EOS) Risk Calculator

Houston Methodist EOS Sequence Algorithm (\\epic-nas.et0922.epichosted.com\static\OrderSets\Houston Methodist EOS Sequence Algorithm.pdf)

- ☒ **Early onset sepsis (EOS) risk calculator** Conditional Frequency, Routine, For any infant born at a gestational age 34 weeks or greater and less than 24 hours old with any one of these identified risk factors: chorioamnionitis, maternal fever, ruptured membranes > 18 hours, and maternal GBS status of positive or unknown, apply the EOS calculator with a CDC incidence of 0.5/1000 births. Perform a clinical assessment of the infant and classify the clinical appearance into well appearing, equivocal or clinical illness (See Reference Link). If the clinical presentation is equivocal or indicating clinical illness, or if a blood culture or antibiotic use is recommended, notify the physician/physician team immediately and provide results of the EOS calculator with corresponding recommendations based on clinical appearance. Follow vital signs monitoring based on EOS risk calculation.

☐ Antibacterial Medications

☐ Ampicillin

Ampicillin

Neonatal early onset sepsis: IM, IV:
100 mg/kg every 8 hours

General dosing, susceptible infection, non-CNS involvement: IM, IV:
Gestational age LESS than or EQUAL to 34 weeks:
 Postnatal age LESS than or EQUAL to 7 days: 50 mg/kg every 12 hours
 Postnatal age GREATER than 7 days: 75 mg/kg every 12 hours
Gestational age 35 to 43 weeks:
 All: 50 mg/kg every 8 hours
Gestational age GREATER than or EQUAL to 44 weeks:
 Mild/moderate infection: 12.5 – 50 mg/kg every 6 hours
 Severe infection: 50 - 67 mg/kg every 4 hours

Meningitis including Group B streptococcal, empiric therapy or treatment: IV:
 Postnatal age LESS than or EQUAL to 7 days: 100 mg/kg every 8 hours
 Postnatal age GREATER than 7 days: 75 mg/kg every 6 hours

Prophylaxis for patients with asplenia: IV:
50 mg/kg every 12 hours

UTI prophylaxis (hydronephrosis, vesicoureteral reflux): IV:
25 mg/kg every 24 hours

- ☒ **ampicillin (OMNIPEN) in water for injection, sterile (PF) 1 mL IV syringe** 50 mg/kg, intravenous, every 8 hours, STAT
Reconstituted solution must be used within 1 hour.
Reconstitute a 500 mg vial with 5 mL of sterile water for injection preservative free to make 100 mg/mL final concentration. Reconstituted solution must be used within 1 hour.

☐ Gentamicin

Gentamicin

General dosing, susceptible infection: IV
Gestational age LESS than 30 weeks:
 Postnatal age LESS than or EQUAL to 14 days: 5 mg/kg every 48 hours
 Postnatal age GREATER than 14 days: 5 mg/kg every 36 hours
Gestational age 30 to 34 weeks:
 Postnatal age LESS than or EQUAL to 14 days: 5 mg/kg every 36 hours
 Postnatal age GREATER than 14 days: 5 mg/kg every 24 hours
Gestational age 35 to 43 weeks:
 Postnatal age LESS than or EQUAL to 7 days: 4 mg/kg every 24 hours
 Postnatal age GREATER than 7 days: 5 mg/kg every 24 hours

Sign: _____ Printed Name: _____

Date _____
Page 12 of 15

Gestational age GREATER than or EQUAL to 44 weeks:

All: 2.5 mg/kg every 8 hours

☒ **gentamicin (GARAMYCIN) IVPB** intravenous, STAT

Indication: ☐ Sepsis of Unknown Source

☒ **Pharmacy consult to manage aminoglycoside** Until discontinued, STAT

Which aminoglycoside do you need help dosing? ☐ gentamicin

Indication: ☐ Early Onset Sepsis

☐ **Amikacin**

Amikacin

General dosing, susceptible infection: IV

Gestational age LESS than 30 weeks:

Postnatal age LESS than or EQUAL to 14 days: 15 mg/kg every 48 hours

Postnatal age GREATER than 14 days: 15 mg/kg every 24 hours

Gestational age 30 to 34 weeks:

Postnatal age LESS than or EQUAL to 60 days: 15 mg/kg every 24 hours

Gestational age 35 to 43 weeks:

Postnatal age LESS than or EQUAL to 7 days: 15 mg/kg every 24 hours

Postnatal age GREATER than 7 days: 17.5 mg/kg every 24 hours

Gestational age GREATER than or EQUAL to 44 weeks: 5 – 7.5 mg/kg every 8 hours

☒ **amikacin (AMIKIN) in sodium chloride 0.9% 1 mL IV syringe** intravenous, STAT, 30.000 Minutes

☐ **cefTAZidime**

Ceftazidime

General dosing, susceptible infection: IM, IV:

Body weight LESS than 1 kg:

Postnatal age LESS than or EQUAL to 14 days: 50 mg/kg every 12 hours

Postnatal age GREATER than 14 days: 50 mg/kg every 8 hours

Body weight 1 to 2 kg:

Postnatal age LESS than or EQUAL to 7 days: 50 mg/kg every 12 hours

Postnatal age GREATER than 7 days: 50 mg/kg every 8-12 hours

Body weight GREATER than 2 kg:

Postnatal age LESS than or EQUAL to 7 days: 50 mg/kg every 12 hours

Postnatal age 8 to 60 days: 50 mg/kg every 8 hours

Meningitis: IV

Postnatal LESS than or EQUAL to 7 days: 50 mg/kg every 8-12 hours

Postnatal GREATER than 7 days: 50 mg/kg every 8 hours

☒ **cefTAZidime ((FORTAZ)) injection** 50 mg/kg, intravenous, every 12 hours, STAT

Cardiology

Imaging

Diagnostic Study

☐ **Chest And Abdomen Child** 1 time imaging, Routine

Is the patient pregnant?

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 1 Vw Portable** 1 time imaging, Routine

Is the patient pregnant? ☐ No

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **XR Abdomen 1 Vw Portable** 1 time imaging, Routine

Is the patient pregnant?

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Other Studies

Respiratory

Oxygen Therapy / Ventillation

☐ **Blow-by oxygen** As needed, Routine, May administer oxygen to maintain saturation greater than 95%. Call MD if activated.

Indications for O2 therapy: ☐ Hypoxemia

Rate in liters per minute:

FiO2:

Sign: _____ Printed Name: _____ Date _____

☐ **Oxygen therapy** Continuous, Routine

Device:

Device:

Titrate to keep O2 Sat Above: 92%

Indications for O2 therapy:

☐ **Oxygen therapy-Nasal Cannula** Continuous, Routine

Device: o Nasal Cannula

Device:

Titrate to keep O2 Sat Above: 92%

Indications for O2 therapy:

☐ **Oxygen therapy-High Flow Nasal Cannula (HFNC)** Continuous, Routine

Device: o High Flow Nasal Cannula (HFNC)

Device:

Titrate to keep O2 Sat Above: 92%

Indications for O2 therapy:

☐ **CPAP** Continuous, STAT

Instructions for As Directed:

Bubble CPAP:

Mode: Spontaneous

CPAP (cm H2O):

O2 Bleed In (L/min):

FiO2:

Titrate to keep O2 Sat Above:

☐ **Neonatal mechanical vent** Continuous, Routine

Mechanical Ventilation:

☐ **Neonatal NPPV** Once, Routine

Mask Type:

Resp Rate (breaths/min):

O2 Bleed In (L/min):

Inspiratory Pressure (cm H2O):

Expiratory Pressure (cm H2O):

FiO2:

☐ **BIPAP** Once, Routine, At bedtime

Instructions for As Directed:

Mode:

☐ **High frequency oscillatory ventilation** Continuous, STAT

Frequency (5 - 6 Hz):

Amplitude:

% Inspiratory Time:

MAP:

FiO2:

Rehab

Consults

For Physician Consult orders use sidebar

Chorioamnionitis

Chorioamnionitis

☐ **Vital signs - T/P/R/BP** Every 4 hours, Routine

☐ **Insert peripheral IV** Once, Routine

☐ **Assess IV site** Every 4 hours, Routine

☐ **Confirm blood culture results** Once, 1, Occurrences, S+2, Routine, Confirm blood culture results after 48 hours. Positive cultures: Notify physician immediately and initiate transfer process. Negative cultures: Discontinue peripheral IV and start vital signs every 8 hours.

Sign: _____ Printed Name: _____ Date _____

☐ **Notify Physician for vitals or signs and symptoms of sepsis:** Until discontinued, Routine, Notify practitioner immediately if the patient displays signs and symptoms of sepsis.

Temperature greater than: ☐ 99.3 ☐ 100.5

Temperature less than: ☐ 97.7

Systolic BP greater than: ☐ 70 ☐ 160

Systolic BP less than: ☐ 50 ☐ 90

Diastolic BP greater than: ☐ 45 ☐ 100

Diastolic BP less than: ☐ 30 ☐ 50

Heart rate greater than (BPM): ☐ 160 ☐ 100

Heart rate less than (BPM): ☐ 100 ☐ 60

Respiratory rate greater than: ☐ 60 ☐ 25

Respiratory rate less than: ☐ 30 ☐ 8

SpO2 less than: ☐ 90 ☐ 92

MAP less than: 60.000

☐ **Aerobic culture** Once, Routine

Ancillary Consults

☐ **Consult to PT eval and treat** Once, Routine

Reasons for referral to Physical Therapy (mark all applicable):

Are there any restrictions for positioning or mobility?

Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):

Weight Bearing Status:

Reason for PT?

☐ **Consult to OT eval and treat** Once, Routine

Reason for referral to Occupational Therapy (mark all that apply):

Are there any restrictions for positioning or mobility?

Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):

Weight Bearing Status:

Reason for OT?

☐ **Consult to Speech Language Pathology** Once, Routine

Reason for consult:

Reason for SLP?

☐ **Consult to Social Work** Once, Routine

Reason for Consult:

Reason for Consult?

☒ **Consult to Spiritual Care** Once, Routine

Reason for consult?

Reason for Consult?

Sign: _____ Printed Name: _____ Date _____