George Mark Children's House

Doctor's Admission Orders

DOUBLE BOXED AREA IS MANDATORY: COMPLETE *ALL* ITEMS IN THIS SECTION

Last Name: First Name:
DOB: Gender: Girl Boy

Weight: Height:

ADMIT TO: Respite Transitional Care End of Life Care Pain and Symptom Management

DIAGNOSIS: _____

ICD 10 CODES: _____ _____ _____ _____ _____ _____

ALLERGIES :(drugs, food, environmental:) SHELLFISH_____

TB TEST COMPLETED: Yes RESULTS in mm:_____ Date: _____

If not screened: Does child have risk factors per CDC guidelines?
Yes No

IMMUNIZATION STATUS: Up-to-Date Other: _____

INFLUENZA VACCINE GIVEN FOR CURRENT YEAR: Yes No /

If no, reason:

OK TO USE WHEELCHAIR POSTURAL SUPPORTS (harness, tray) Yes No N/A

OK TO USE OTHER PHYSICAL RESTRAINTS (soft mittens, no-no's) Yes No N/A

OK TO ***NOT*** DO BOWEL AND BLADDER TRAINING WITH PATIENT : Yes No N/A

Reason:

OK TO ***NOT*** NOTIFY PMD OF PATIENT'S CHANGE IN WEIGHT OF 5LBS OR MORE Yes No N/A

OK TO CONSULT WITH GMCH On-Call MD FOR ORDERS, as needed Yes No

Please indicate child's code status, either: Allow Natural Death (DNR) OR Full Code

MANDATORY: Orders will be returned if no code status is designated

Allow Natural Death (AND)

Full Code (INITIATE BLS AND CALL 911)

Comment: _____

PLEASE NOTIFY ME OF CHILD'S DEATH: At Time of Death Following Morning

PARENTS MAY ADMINISTER ALL MEDICATIONS: Yes No N/A

ADMINISTER ALL MEDICATIONS UNTIL TIME OF DISCHARGE? Yes No N/A

ACTIVITY: Activity as Tolerated:

Restricted (please describe):_____

May use of GMCH hydrotherapy pool: Yes No

May go out on a pass for a scheduled activity/clinic visit not to exceed 48 hours?
Yes No

Can interact with pets/animals: Yes No

VITAL SIGNS while at GMCH: NONE PRN T RR P BP

Other: _____

Physician Name (please print), date and time:_____

Physician Signature: _____

Last Name: **First Name:**

DOB: **Gender:** **Girl** **Boy**

1 **VENOUS ACCESS:** Not Applicable

Central Line Single Lumen *or* Double Lumen

PICC _____ FR

MediPort/Port-A-Cath _____ (size of Huber needle)

Flush: Heparinized saline_____ units per mL, _____ mL, IV, Q _____

Saline _____ mL, IV, Q _____

Date last flushed: _____ Date port last accessed: _____

Topical anesthetic per protocol prior to any access: _____ (please indicate)

LAB ORDERS/Frequency: Not Applicable _____

_____

_____

_____

RESPIRATORY CARE: Not Applicable

O2 liters/min. via: **Nasal Cannula** Mask C/BiPaP Trach Vent

Continuous **PRN:** _____

Nasal/Oral Suction: PRN Other: _____

CPT: **Frequency:** ____ _____ **DURATION: .** **Vest** Manual

Tracheostomy Care: Type of trach: _____ Size of Trach: _____

Trach last changed (date):_____ Next change due (date):_____

Trach Care: Per Parent *or* Other: _____

_____

STRICT INTAKE AND OUTPUT **Yes** **or** **NO**

Diet:

Regular as Tolerated NPO NPO except for meds

Other, Comment: **Feeding Instructions Per Parent Protocol**

NGT/NJT/GT/JT for: feeds meds (define below)

Feeding Instructions/ Schedule: _____

GT/NGT/NJT Type & Size: Cm. Balloon filled with: mls H20 Last changed: _____

Physician Name (please print), date and time:_____

Physician Signature: _____

Last Name:	**First Name:**
DOB:	**Gender:** **Girl** **Boy**

MEDICATIONS:

MEDICATIONS: (Please fill out frequency, mg dose and route, otherwise orders will be considered incomplete and will be sent back)

Medication	Concentration	Dose/mg	Frequency	Route	Notes

OTHER TREATMENTS/DRESSINGS/WOUND CARE:_ _____

NOTIFY M.D:_____

DISCHARGE HOME WITH PARENT/GUARDIAN AT END OF INPATIENT STAY: MM/DD/YY

Within expectation, this patient has the possibility of termination of life within five years or less, based on diagnosis. [Health and Safety Code 1250 (1)(2)(B)]

Physician Name (please print), date and time:_____

Physician Signature: _____