

PHYSICIAN'S ORDER (EXCLUDING IV Fluids and MEDICATIONS)	INTRAVENOUS FLUID and MEDICATION ORDERS
<p>DATE: _____ TIME: _____</p> <p>ADMIT to Intermediate Care Nursery (ICN)</p> <p>DIAGNOSIS: _____</p> <p>CONDITION: _____</p> <p>VITAL SIGNS:</p> <p><input type="checkbox"/> Every 4 hours</p> <p><input type="checkbox"/> Every 4 hour with BP</p> <p><input type="checkbox"/> Every 4 hours with BP x24 hours, then daily</p> <p><input type="checkbox"/> BP every shift</p> <p><input type="checkbox"/> BP daily</p> <p><input type="checkbox"/> BP on all extremities x1</p> <p><input type="checkbox"/> Other _____</p> <p>Goal BP MAP _____</p> <p><u>O2 saturation monitoring:</u></p> <p><input type="checkbox"/> Continuous until specified <input type="checkbox"/> Every 4 hours <input type="checkbox"/> Every shift <input type="checkbox"/> Daily <input type="checkbox"/> Spot check <input type="checkbox"/> Prior to discharge</p> <p><input type="checkbox"/> Other _____</p> <p><u>Cardiac monitoring:</u></p> <p><input type="checkbox"/> Continuous until specified <input type="checkbox"/> Not needed at this time</p> <p>Other: _____</p> <p>DIET:</p> <p><u>Mode of feeding:</u></p> <p><input type="checkbox"/> NPO <input type="checkbox"/> Oral <input type="checkbox"/> OGT/NGT <input type="checkbox"/> PO/gavage feed</p> <p><u>Type of feeding:</u></p> <p><input type="checkbox"/> Breastmilk <input type="checkbox"/> Term infant formula</p> <p><input type="checkbox"/> Preterm infant formula <input type="checkbox"/> Soy-based infant formula</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Caloric value:</u></p> <p><input type="checkbox"/> 20 cal/oz <input type="checkbox"/> 22 cal/oz <input type="checkbox"/> 24 cal/oz</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Total fluids _____</p>	<p>ALLERGY: _____ WEIGHT: _____</p> <p>MEDICATIONS:</p> <p>Prophylactic Medications</p> <p><input type="checkbox"/> Erythromycin ophthalmic ointment- place a ribbon of ointment across each eye, one time</p> <p><input type="checkbox"/> Aquamephyton- 1 mg IM to thigh, one time</p> <p><input type="checkbox"/> Hepatitis B vaccine- 5 mcg IM to thigh, one time</p> <p><input type="checkbox"/> Hepatitis B Immune Globulin- 0.5 ml IM to thigh, one time if mother of infant is/has:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Hepatitis B Surface Antigen positive</p> <p style="padding-left: 20px;"><input type="checkbox"/> No prenatal care</p> <p style="padding-left: 20px;"><input type="checkbox"/> Inadequate prenatal care</p> <p><input type="checkbox"/> Bacitracin ointment- to be used topically for any abrasions, fetal scalp electrode lesions, or for open wounds</p> <p style="padding-left: 20px;"><input type="checkbox"/> TID, until healed</p> <p style="padding-left: 20px;"><input type="checkbox"/> as needed, until healed</p> <p>Antibiotics</p> <p><input type="checkbox"/> Ampicillin 50 mg/kg/dose IV every 12 hours: _____</p> <p><input type="checkbox"/> Ampicillin 75 mg/kg/dose IV every 12 hours: _____</p> <p><input type="checkbox"/> Ampicillin 100 mg/kg/dose IV every 12 hours: _____</p> <p><input type="checkbox"/> Gentamicin 4 mg/kg/dose IV every 24 hours: _____</p> <p><input type="checkbox"/> Gentamicin 4.5 mg/kg/dose IV every 36 hours: _____</p> <p><input type="checkbox"/> Gentamicin 5 mg/kg/dose IV every 48 hours: _____</p> <p><input type="checkbox"/> Other: _____</p>
<p><input checked="" type="checkbox"/> Summary/Blanket orders are unacceptable.</p> <p><input checked="" type="checkbox"/> Medication orders must be complete.</p> <p><input checked="" type="checkbox"/> PRN medication orders must include an indication.</p> <p><input checked="" type="checkbox"/> Write legibly.</p> <p><input checked="" type="checkbox"/> Rewrite orders upon transfer and/or post-operatively.</p> <p><input checked="" type="checkbox"/> Date, time, and sign verbal & telephone orders within 48 hours.</p>	<p>DO NOT USE:</p> <p>U MS</p> <p>IU MSO₄</p> <p>Q.D. MgSO₄</p> <p>Q.O.D. Trailing zero</p> <p>Lack of leading zero</p>
<div style="border: 1px solid black; width: 100px; height: 40px; display: inline-block;"></div> <p>Physician's Initials</p>	

IVF and MEDICATION ORDERS ONLY

**Physician's Order Form
ICN Admission Orders**

PATIENT ID LABEL

