

PHYSICIAN'S ORDER (EXCLUDING IV Fluids and MEDICATIONS)		INTRAVENOUS FLUID and MEDICATION ORDERS
<p><b>Pediatrics Acute Gastroenteritis Admission Orders</b></p> <p><b>Date:</b> _____ <b>Time:</b> _____</p> <p><b>Admitting Physician:</b> _____</p> <p><b>Admit to:</b> <input type="checkbox"/> Regular Pediatrics <input type="checkbox"/> PICU</p> <p><b>Diagnosis:</b> _____</p> <p><b>Condition:</b> <input type="checkbox"/> Stable <input type="checkbox"/> Guarded <input type="checkbox"/> Critical</p> <p><b>Vital Signs:</b> (TPR, BP, SpO2)  <input type="checkbox"/> Every 4 hours <input type="checkbox"/> Other: _____</p> <p><b>Diet:</b>  <input type="checkbox"/> Advance diet as tolerated starting with oral rehydration solution  <input type="checkbox"/> Resume breastfeeding as soon as possible  <input type="checkbox"/> Breastfeeding tray for mom  <input type="checkbox"/> NPO, strict  <input type="checkbox"/> NPO except medication  <input type="checkbox"/> NPO except sips of clear liquids, 4 hours post last emesis</p> <p><b>Activity:</b>  <input type="checkbox"/> Progress as tolerated <input type="checkbox"/> Bed rest</p> <p><b>Nursing Orders:</b>  <u>Assessments</u>                      Measure weight and height on admission  <input type="checkbox"/> Measure weight daily  <input type="checkbox"/> Cardiorespiratory monitor  <input type="checkbox"/> Measure head circumference on admission (indicated for children &lt; 2 years)  <input type="checkbox"/> Routine intake and output  <input type="checkbox"/> Strict intake and output</p> <p><u>Contingency</u></p> <ul style="list-style-type: none"> <li>• Notify physician of bilious emesis</li> <li>• Notify physician of uncontrolled pain</li> </ul>	IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY	<p><b>ALLERGY (describe allergic reaction):</b></p> <p><input type="checkbox"/> NKDA</p> <p>Weight _____ kg</p> <p><b>IV Fluids:</b>  <input type="checkbox"/> IV Fluid Bolus                      _____ mL of 0.9% Sodium Chloride IV (20mL/kg/dose) over 20-30 minutes                      Indication: DEHYDRATION <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> <p><u>IV Maintenance</u>                      Maintenance fluids:                      &lt;10kg: 100mL/kg/24hrs                      10-20kg: 1L plus 50mL/kg/24hrs for each kg &gt;10kg                      &gt;20kg: 1.5L plus 20mL/kg/24hrs for each kg &gt;20kg</p> <p>Estimation of Dehydration:                      Weight loss for infants:                      5% Mild; 10% Moderate; 15% Severe                      Weight loss for children:                      3-4% Mild; 6-8% Moderate; 10% Severe                      Fluid deficit:                      Mild &lt;50mL/kg                      Moderate 50-100mL/kg                      Severe &gt;100mL/kg</p> <ol style="list-style-type: none"> <li>1. After initial fluid bolus(es), for the first 8 hours, give 1/3 of daily maintenance fluids plus 1/2 of fluid deficit.</li> <li>2. For the next 16 hours, give 2/3 of the daily maintenance plus 1/2 of deficit fluids.</li> <li>3. Replace ongoing losses with LR or NS.</li> </ol> <p><input type="checkbox"/> _____ mL/hr of D5IP  <input type="checkbox"/> _____ mL/hr of D5/0.2% NaCl with 20mEq KCl/L  <input type="checkbox"/> _____ mL/hr of D5/0.3% NaCl with 30mEq KCl/L  <input type="checkbox"/> _____ mL/hr of D5/0.45% NaCl with 20mEq KCl/L  <input type="checkbox"/> _____ mL/hr of other (specify) _____</p>

- ✓ Summary/Blanket orders are unacceptable.
- ✓ Medication orders must be complete.
- ✓ PRN medication orders must include an indication.
- ✓ Write legibly.
- ✓ Rewrite orders upon transfer and/or post-operatively.
- ✓ Date, time, and sign verbal & telephone orders within 48 hours.

**DO NOT USE:**  
 U MS  
 IU MSO<sub>4</sub>  
 Q.D. MgSO<sub>4</sub>  
 Q.O.D. Trailing zero  
 Lack of leading zero

Physician's  
Initials

**Physician's Order Form  
 Pediatrics Acute Gastroenteritis Admission Orders**

Patient ID Label

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<p><b>Education:</b></p> <input type="checkbox"/> Provide diet education regarding the appropriate utilization of an oral electrolyte solution and initiation of an age-appropriate diet following rehydration. <p><b>Labs:</b></p> <p><u>Panels</u></p> <input type="checkbox"/> CBC with manual WBC differential <input type="checkbox"/> Chem7 <p><u>Microbiology</u></p> <input type="checkbox"/> Culture, Blood <input type="checkbox"/> Culture, Urine (via clean catch) <input type="checkbox"/> Culture, Urine (via direct catheterization) <input type="checkbox"/> Culture, Stool <input type="checkbox"/> Stool Rotavirus, direct detection <input type="checkbox"/> Stool occult blood <input type="checkbox"/> Stool C. Difficile <p><u>Urinalysis</u></p> <input type="checkbox"/> Urinalysis (UA) with microscopy <p><b>Radiology:</b></p> <input type="checkbox"/> Ultrasound, abdomen <input type="checkbox"/> Abdominal x-ray, AP <input type="checkbox"/> Chest x-ray, 2 views <input type="checkbox"/> Upper gastrointestinal series <input type="checkbox"/> Upper gastrointestinal series with small bowel follow through <input type="checkbox"/> Indication(s) for any chosen above: <hr/> <hr/>	IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY IVF and MEDICATION ORDERS ONLY	<p><b>ALLERGY (describe allergic reaction):</b></p> <p><input type="checkbox"/> NKDA</p> <p><b>Medications:</b></p> <p><u>Pain and Fever Medications:</u></p> <p><input type="checkbox"/> <b>Acetaminophen</b>                  _____ mg PR <input type="checkbox"/> q4hrs <input type="checkbox"/> q6hrs PRN fever/pain 1-5/10                  (10-15mg/kg/dose) Max dose: 2600mg/24hrs</p> <p><input type="checkbox"/> <b>Acetaminophen</b>                  _____ mg PO <input type="checkbox"/> q4hrs <input type="checkbox"/> q6hrs PRN fever/pain 1-5/10                  (10-15mg/kg/dose) Max dose: 90mg/kg/24hrs</p> <p><input type="checkbox"/> <b>Acetaminophen with Codeine</b> *Age over 3yrs                  _____ mg Codeine PO <input type="checkbox"/> q4hrs <input type="checkbox"/> q6hrs PRN pain &gt; 5/10                  (0.5-1mg Codeine/kg/dose) Max dose: 360mg/24hrs</p> <p><input type="checkbox"/> <b>Ibuprofen</b> * Age ≥ 6 months                  _____ mg PO <input type="checkbox"/> q6hrs <input type="checkbox"/> q8hrs PRN fever/pain 1-5/10                  (5-10mg/kg/dose) Max dose: 40mg/kg/day</p> <p><u>Special Medications:</u>                  Severe Gastroenteritis with Fever, Gross Blood and Neutrophils in Stool (E. coli, Shigella, Salmonella):</p> <p><input type="checkbox"/> <b>Ceftriaxone</b> (Rocephin) 50-75mg/kg/day <input type="checkbox"/> IV <input type="checkbox"/> IM  <input type="checkbox"/> ÷ q12hrs <input type="checkbox"/> q24hrs (max 4grams/day) _____ mg/dose</p> <p><input type="checkbox"/> <b>Ampicillin</b> 100-200mg/kg/day IV ÷ q6hrs                  (max 12grams/day or 50-100mg/kg/day) _____ mg/dose</p> <p><input type="checkbox"/> <b>Trimethoprim/Sulfamethoxazole</b> (Bactrim, Septra)                  10mg TMP/kg/day PO ÷ BID <input type="checkbox"/> x 5days <input type="checkbox"/> x 7days                  (max 320mg TMP/day) susp per 5mL TMP 40mg/ SMX 200mg; Tab DS TMP 160mg/SMX 800mg; tab SS TMP 80mg/SMX 400mg</p>
<p><b>Consults:</b></p> <input type="checkbox"/> Surgery Consult: _____ <hr/> <p><input type="checkbox"/> Discharge planning or case management:</p> <p><input type="checkbox"/> Placement _____</p> <p><input type="checkbox"/> Home Care _____</p> <p><input type="checkbox"/> Durable Medical Equipment _____</p> <input type="checkbox"/> Dietitian, pediatric		

<ul style="list-style-type: none"> <li>✓ Summary/Blanket orders are unacceptable.</li> <li>✓ Medication orders must be complete.</li> <li>✓ PRN medication orders must include an indication.</li> <li>✓ Write legibly.</li> <li>✓ Rewrite orders upon transfer and/or post-operatively.</li> <li>✓ Date, time, and sign verbal &amp; telephone orders within 48 hours.</li> </ul>	<p><b>DO NOT USE:</b></p> U MS IU MSO <sub>4</sub> Q.D. MgSO <sub>4</sub> Q.O.D. Trailing zero Lack of leading zero	<div style="border: 1px solid black; width: 100px; height: 40px; margin-bottom: 5px;"></div> Physician's Initials
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**Physician's Order Form**

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Guam Memorial Hospital Authority

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Form# CPOE-008

