Cincinnati Children's Hospital Medical Center

PHYSICIAN'S ORDER FORM

Name _____
MR#_____ DOB _____

All orders must be written in the metric system and include date, time, physician's signature and pager/phone number. Use ball point pen.

Birth Weight _____KG (_____ LB _____ OZ) Current Weight _____ KG (_____ LB _____ OZ)

Gestational Age_____ weeks Hour/Time of Birth _____

Total Serum Bilirubin Level _____mg/dl Date: _____ / Time: _____ level obtained

Nutrition: ☐ Breastfed ☐ Formula: type _____

Allergies: ☐ None ☐ Drug/Contrast ☐ Food ☐ Product/Latex Specifics:_____

HOME HEALTH CARE PHOTOTHERAPY ORDERS

Clinical Criteria for Home Phototherapy

1. Total Serum Bilirubin level must be obtained no more than eight (8) hours prior to time of the referral.
2. Patient's Total Serum Bilirubin level falls within recommended range for home phototherapy, based on hours of age and gestational age. (Refer to Bilirubin Level Tracking Sheet and the American Academy of Pediatrics Clinical Practice Guidelines, 2004.)
3. Infant is 35 weeks gestation or greater and is between 24 hours and 7 days of age.
4. Infant shows no signs/symptoms of dehydration, significant lethargy, or temperature instability.
5. Infant shows no signs/symptoms of sepsis or acidosis.
6. If the infant is exclusively breast feeding, there are no signs/symptoms of poor nursing and ≥ 10% weight loss.
7. There is no evidence of active hemolysis.

Home Phototherapy Orders

1. Equipment for home phototherapy to be provided by CCHMC Home Health Care. Set unit to HIGH intensity.
2. CCHMC Home Health Care nurse is to make an initial home visit on _____ (date) to educate family on safe use of equipment and infant monitoring during home phototherapy. Blanket is to be applied continuously except for daily bathing, clothing and diaper changes, and skin assessments.

   If Ohio Medicaid: I had a face to face encounter on _____ (date). **Addendum:** The clinical findings support Home Health eligibility because _____.
3. Nurse to visit daily, unless otherwise ordered. Nurse will weigh and assess patient; obtain feeding and output history; and draw conjugated and unconjugated bilirubin levels.
4. Nurse will call the daily assessment and lab results, and will fax updated Bilirubin Level Tracking Sheet to the physician. Fax number: _____
5. Special feeding instructions:_____
6. Other orders (e.g. additional labs): _____

Physician Signature/Credentials **PRINT NAME** **Pager** **Time/Date**

Please fax the completed orders to Home Care (513) 636-7538. If CCHMC patient, place original in medical record.

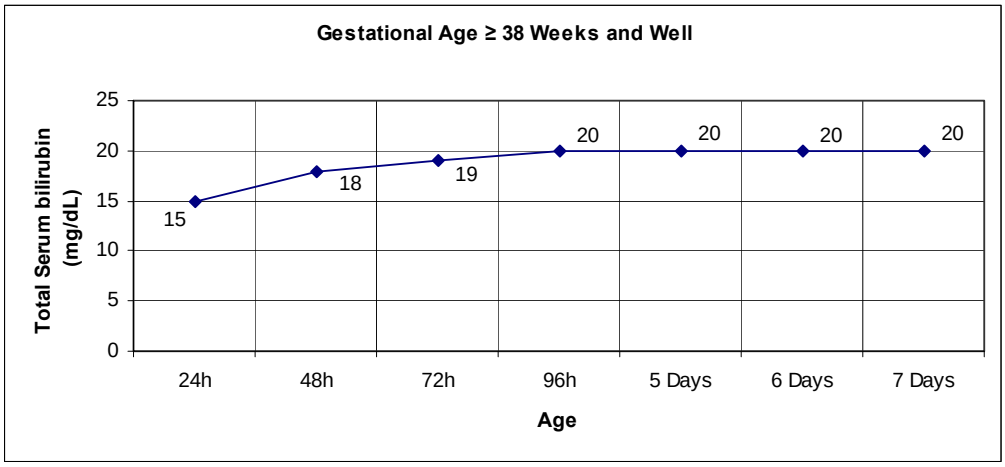
Orders faxed on: (date) _____ at (time) _____by (print name) _____

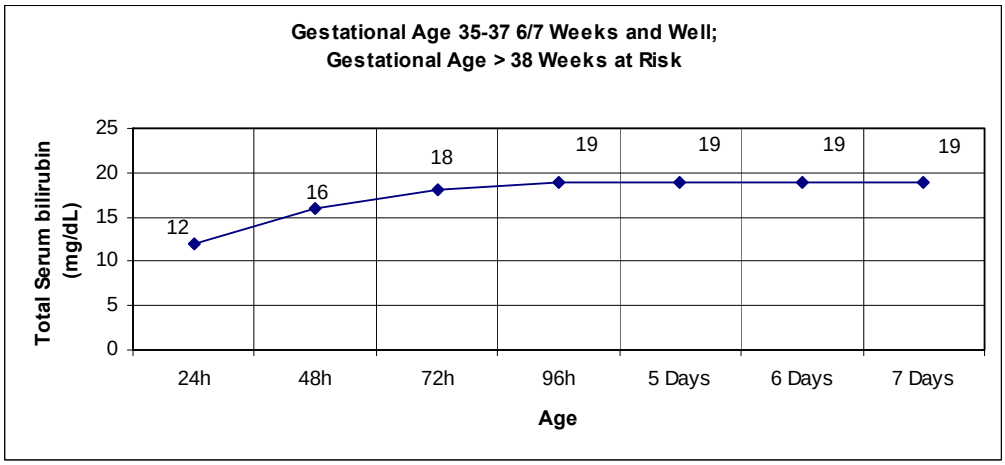
DTA0123

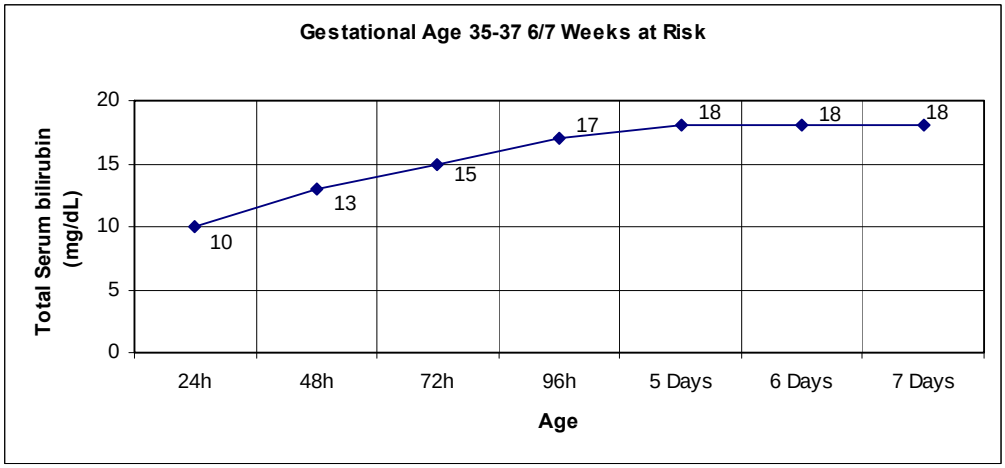
Bilirubin Level Tracking Sheet

Treatment recommendations are based on guidelines published by the American Academy of Pediatrics, 2004:

- Levels that fall **ABOVE** the line are recommended for inpatient admission.







Date	Time	Hours of Age	Total Serum bilirubin mg/dL	Nurse's Signature/Credentials