

Name:

DOB:

MR:

NUTRITION

| | | | |
|---------------------------------|--|-------------------------------|--------------|
| Admission wgt: | | Discharge wgt: | |
| Formula Recipe: | | | |
| Feeding Schedule: | | | |
| Route: | | Tube size/Type: | Rate/Method: |
| Water Flushes | | Other intake: | |
| Total Enteral Feeds (24 hours): | | Total Oral intake (24 hours): | |
| Education needed: | | | |

RESPIRATORY

| | | | |
|------------------------------|-----------------|---------------|---------------------|
| Trach type/size: | Cuff inflation: | Backup trach: | Trach Manual Given: |
| Ventilator Support Settings: | | | |
| Other Equipment/Supplies: | | | |
| Studies needed: | | | |

CVC ACCESS

| | | |
|---------------------------------------|-----------------------------|-----------|
| Date placed: | Type/Size: | Location: |
| External length (PICC) | Supplies ordered Y/N, Date: | |
| Infusion Company: phone#: Fax#: | | |

Name:

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Checklist:

- Teaching Complete
 - 24 Hour stay complete
 - Medications Filled
 - DNR status confirmed
 - Insurance Approval for all care
 - DME approved / received
 - Orders sent to: home care DME school parents
 - Transportation home
 - Transportation to appointments
 - Items / issues pending
- Caregiver #1
 - Caregiver #1
- Caregiver #2
 - Caregiver #2

FOLLOW-UP APPOINTMENTS

| |
|-----------------------------------------|
| Physician / Department: Date / Time: |
| Physician / Department: Date / Time: |
| Physician / Department: Date / Time: |
| Physician / Department: Date / Time: |
| Physician / Department: Date / Time: |

LABS/STUDIES PENDING: