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

HOME HEALTH CARE PHOTOTHERAPY ORDERS

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: _____

Diagnosis: _____

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 (no more than 1 point above phototherapy threshold), based on hours of age and gestational age. (Refer to the American Academy of Pediatrics Clinical Practice Guidelines, 2022.)
3. Infant is 36 weeks gestation or greater and is between 48 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 weight loss is less than 10%.
7. There is no evidence of active hemolysis.
8. No previous phototherapy (unless continuous from birth hospital).
9. Albumin if measured is greater than 3.0.
10. Infant will be able to have labs checked daily or as ordered by the prescribing physician.

Home Phototherapy Orders

1. Equipment for home phototherapy to be provided by CCHMC Home Health Care. Set unit to HIGH intensity.

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