RESPITE ADMISSION ORDERS

Physician signature must be present to complete orders

Your patient, ____, will be receiving respite care at Ryan House. All orders are reviewed with each stay. Any additions, deletions or changes will result in a need for new orders. A medical director is always available for consultation about any aspect of palliative care.

Diagnosis ____ Physician / Practitioner ______________________________

1. Each discipline (nurse, social worker, child life specialist, chaplain, certified nursing assistant, volunteer) may visit as frequently as needed to meet the child and family needs, and as approved by the interdisciplinary team.
2. Our care team may accept orders from primary care physician/practitioner partners and/or call group when needed.
3. The legal representative's wishes, or if applicable, the child's wishes, regarding resuscitation attempts are
   ☐ Allow natural death (DNR) ☐ Attempt resuscitation and call 911
4. May participate in therapies such as art, music, media, sensory and hydrotherapy.
5. Durable medical equipment (DME) as indicated for child's condition.
6. Respiratory orders (trach / vent / CPAP / BiPAP require addition order forms):
   Oxygen at ________________ LPM via nasal cannula/mask/blow-by ☐ Continuous ☐ PRN dyspnea/comfort
   Keep O_2 stats > ____________________________ Pulse oximetry: ☐ Continuous ☐ Intermittent
   ☐ Suction PRN and per child's normal routine ☐ SVN's used (order must be on medication list, page 2)
7. CPT: ☐ Manual ☐ Vest Settings __________ Cycles ___________ Frequency ______________________________
8. Cough assist settings _________________________ Cycles ___________ Frequency ______________________________

Bowels	Diet
☐ Miralax ☐ Glycerin Suppository Give per parent direction.	Formula ___________ Rate ___________ Route ___________ ☐ Enteral ☐ Oral ☐ Special: _________________________ ____
Pain / Fever	
☐ Tylenol ☐ Ibuprofen Give per parent direction.	☐ For nausea / vomiting use Pedialyte per parent instruction. ☐ If diet has changed, may follow current home routine per parent instruction.

Unless otherwise indicated, your signature below affirms parent/child decision regarding resuscitation. Agrees with the Plan of Care and authorizes the care team to initiate changes as needed. Authorizes consult by the Medical Director, if indicated.

Physician/Practitioner fax ____

Physician/Practitioner signature ____ Date ____________________

Physician/Practitioner, please sign and return; your signature also indicates approval of the medication orders.

Guardian signature ____ Date ____________________

Child name ____________________________________ DOB ____________________ Child ID __________________

MEDICATION LIST

☐ NKA or allergies ____________________

Diagnosis ____________________

Prohibited abbreviations: U, IU, ug, QD, qd, QOD, qod, $MgSO_4$, MSO_4, trailing zeros

Medication Generic equivalent may be substituted	Dosage with concentration	Frequency	Route	Reason	Covered HOV kids
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no

Alternative medications (list) ____________________

____

Infusion Orders

☐ Heparin — Must include concentration in units/ml ____________________

☐ Peripheral — Flush (solution/frequency/amount) ____________________

Change site (frequency) ____________________

☐ PCC — Flush (solution/frequency/amount) ____________________

Dressing change (frequency) ____________________

☐ Implantable port — Flush (solution/frequency/amount) ____________________

If continuous infusion, frequency of needle change ____________________

☐ Central line — Flush (solution/frequency/amount) ____________________

Dressing change (frequency) ____________________

Child name ____________________ DOB ____________________ Child ID ____________________