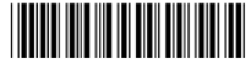
(place patient label here)

Patient Name:_________________________

Order Set Directions:

- (√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.
- Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made
- Initial each page and Sign/Date/Time last page



PROVIDER ORDERS

Diagnosis: ____

Allergies with reaction type:____

NICU DART Corticosteroid Taper Dosing

Version 1 Approved 02/06/18

Medications

Intravenous Corticosteroids:

dexamethasone (DECADRON) 0.1 mg/ml dilution

- ☐ 0.075 mg/kg intravenously every 12 hours for 3 days, then
- ☐ 0.05 mg/kg intravenously every 12 hours for 3 days, then
- ☐ 0.025 mg/kg intravenously every 12 hours for 2 days, then
- ☐ 0.01 mg/kg intravenously every 12 hours for 2 days

Oral Corticosteroids:

dexamethasone (DECADRON) 0.1 mg/ml oral solution

- ☐ 0.075 mg/kg orally every 12 hours for 3 days, then
- ☐ 0.05 mg/kg orally every 12 hours for 3 days, then
- ☐ 0.025 mg/kg orally every 12 hours for 2 days, then
- ☐ 0.01 mg/kg orally every 12 hours for 2 days

Provider Signature:____Date:__________Time:_________