

(place patient label here)

Patient Name: _____



PROVIDER ORDERS

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

Diagnosis: _____

Allergies with reaction type: _____

NICU Lumbar Puncture

Version 2 1/21/16

General

- Order for procedure
Specific Procedure: Lumbar Puncture
Date of Procedure: _____
Time of Procedure: _____
Obtain the Written Authorization for Ordered Procedure Except for Procedures Performed In Interventional Radiology

Nursing Orders

- Point of Care: Capillary Blood Glucose
 once prior to procedure

Laboratory

Cerebrospinal Fluid Studies Tube One

- CSF GLUCOSE
- CSF PROTEIN

Cerebrospinal Fluid Studies Tube Two

- CULTURE, FLUID AND GRAM STAIN

Cerebrospinal Fluid Studies Tube Three

- FLUID CELL COUNT WITH DIFF Fluid Source: Cerebrospinal

Cerebrospinal Fluid Specialty Studies

- MENINGITIS PANEL BY PCR MIC Source: CSF
- VIRAL CULTURE, NON-RESPIRATORY
- CULTURE, FUNGAL MIC Source: CSF
- CMV BY PCR (NON-BLOOD SAMPLES)
- FLUID, HERPES SIMPLEX VIRUS PCR MIC Source: CSF
- Toxoplasma gondii, DNA by PCR, cerebrospinal fluid

Provider Signature: _____ Date: _____ Time: _____