

(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 Rounding
Nursing Orders**

Version 2 3/15/17

- Intake and output diaper counts
- Phototherapy Bank x 1
- Phototherapy Bank x 2

Diet

- NPO

Infant Feeding NICU

- Type of Baby Feeding: _____
- Route: _____
- Feeding Frequency: _____
- Calories per ounce: _____
- Volume (mL): _____
- Additive: _____
- IV+PO= _____
- Additional Feeding Comment: _____

Laboratory

Manual differential is done with all CBC/AUTO DIFF orders on patients less than 2 years old

- CBC/AUTO DIFF
- N14
- N8

Blood gas study

- Arterial
- Capillary
- Bilirubin, Neonatal

Radiology and Diagnostic Tests

XR chest single (CXR) - portable

- Reason for exam: _____

XR Abdomen 1 view - portable

- Reason for exam: _____

US Brain

- routine on _____ Reason for exam: _____

Echocardiogram, transthoracic

- routine Reason for exam: _____

Consults

Physician to physician notification preferred.

- Consult to social services / care coordination
- Consult other provider _____ regarding

_____ Does nursing need to contact consulted provider? [] Yes [] No

Provider Signature: _____ Date: _____ Time: _____