(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

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:_____

PEDIATRIC CRITICAL CARE DEXMEDETOMIDINE ORDER FORM

Version 3 03/10/2014

Dexmedetomidine 4 micrograms/mL [mix in Normal Saline]

Patient weight: _____

Start infusion at 0.2 micrograms/kg/hour ---
Dose may be titrated 0.05-0.1 micrograms/kg/hour at 10 minute intervals up to 0.7 micrograms/kg/hour as needed to maintain adequate analgesia/sedation

** **CALL PHYSICIAN** if infusion must be increased greater than 0.7 micrograms/kg/hour **
(Absolute max = 1.5 micrograms/kg/hour)

Monitoring parameters: Monitor heart rate and blood pressure due to risk of bradycardia and hypotension

Provider Signature:_____Date:_____Time:_____