

(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: _____

Pediatric-Psychiatric

Version 2 10/24/13

- This pediatric order set is intended for use in patients 1 month through 17 years of age and less than 50 kilograms

Patient Weight: _____

Nursing Orders

- 1:1 observation at all times or _____
- Safe tray (if not already ordered)
- No visitors except parents or guardians
- No television
- No telephone, including cell phone
- No personal technology of any kind
- Notify provider for any relevant change in behavior
- Other: _____

Consults

- Provider to provider notification preferred.
 - Consult to social services / care coordination

Provider Signature: _____ Date: _____ Time: _____