

(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-Seizure Monitoring

Version 2 11/11/2013

- 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

- Seizure precautions
- Suction to bedside
- Oxygen administration available at bedside
- Order Parent Tray
- Have rescue medications readily available
- If lorazepam (ATIVAN) given initiate continuous pulse oximetry
- Notify provider: For seizure activity requiring rescue medication after first dose is given
- Notify provider: If patient has 2 generalized tonic-clonic seizures or 4 seizures of any kind within a 24 hour period
- Other: _____

Medications

Antiepileptics -Rescue Medications

LORazepam (ATIVAN)

- 0.1 milligram/kilogram (____ milligram) (max 3 milligram) intravenous push as needed for seizure activity: generalized tonic-clonic seizure lasting greater than 5 minutes or a cluster of seizures greater than 4 per hour. May repeat once if seizure persists for greater than 5 minutes after first dose
- 0.1 milligram/kilogram (____ milligram) (max 3 milligram) rectally as needed for seizure activity: generalized tonic-clonic seizure lasting greater than 5 minutes or a cluster of seizures greater than 4 per hour. May repeat once if seizure persists for greater than 5 minutes after first dose (Use only if patient does not have IV access)
- Other: _____

Radiology and Diagnostic Tests

Neurodiagnostics

Electroencephalogram (EEG) continuous video monitoring

- from _____ (time/date) to _____(time/date)
- with sleep deprivation from _____(time/date) to _____ (time/date)
- with photo stim _____(date)
- with hyperventilation _____ (date)
- with exercise bike challenge _____ (date)

Provider Signature: _____ Date: _____ Time: _____