The Board of Visitors
ryan house
open doors, open hearts

RESPITE ADMISSION ORDERS

Physician signature must be present to complete orders

Your patient, _____, will be receiving respite care at Ryan House. All orders are reviewed with each stay. Any additions, deletions or changes will result in a need for new orders. A medical director is always available for consultation about any aspect of palliative care.

Diagnosis _____ Physician / Practitioner _____

1. Each discipline (nurse, social worker, child life specialist, chaplain, certified nursing assistant, volunteer) may visit as frequently as needed to meet the child and family needs, and as approved by the interdisciplinary team.
2. Our care team may accept orders from primary care physician/practitioner partners and/or call group when needed.
3. The legal representative's wishes, or if applicable, the child's wishes, regarding resuscitation attempts are
   ☐ Allow natural death (DNR) ☐ Attempt resuscitation and call 911
4. May participate in therapies such as art, music, media, sensory and hydrotherapy.
5. Durable medical equipment (DME) as indicated for child's condition.
6. Respiratory orders (trach / vent / CPAP / BiPAP require addition order forms):
   Oxygen at _____ LPM via nasal cannula/mask/blow-by ☐ Continuous ☐ PRN dyspnea/comfort
   Keep O_2 stats > _____ Pulse oximetry: ☐ Continuous ☐ Intermittent
   ☐ Suction PRN and per child's normal routine ☐ SVN's used (order must be on medication list, page 2)
7. CPT: ☐ Manual ☐ Vest Settings _____ Cycles _____ Frequency _____
8. Cough assist settings _____ Cycles _____ Frequency _____

Bowels	Diet
☐ Miralax ☐ Glycerin Suppository Give per parent direction.	Formula _____ Rate _____ Route _____ ☐ Enteral ☐ Oral ☐ Special: _____ _____
Pain / Fever	
☐ Tylenol ☐ Ibuprofen Give per parent direction.	☐ For nausea / vomiting use Pedialyte per parent instruction. ☐ If diet has changed, may follow current home routine per parent instruction.

Unless otherwise indicated, your signature below affirms parent/child decision regarding resuscitation. Agrees with the Plan of Care and authorizes the care team to initiate changes as needed. Authorizes consult by the Medical Director, if indicated.

Physician/Practitioner fax _____

Physician/Practitioner signature _____ Date _____

Physician/Practitioner, please sign and return; your signature also indicates approval of the medication orders.

Guardian signature _____ Date _____

Child name _____ DOB _____ Child ID _____

MEDICATION LIST

☐ NKA or allergies _____

Diagnosis _____

Prohibited abbreviations: U, IU, ug, QD, qd, QOD, qod, $MgSO_4$, MSO_4, trailing zeros

Medication Generic equivalent may be substituted	**Dosage** with concentration	**Frequency**	**Route**	**Reason**	**Covered** HOV kids
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no
					yes/no

Alternative medications (list) _____

_____

Infusion Orders

☐ Heparin — Must include concentration in units/ml _____

☐ Peripheral — Flush (solution/frequency/amount) _____

Change site (frequency) _____

☐ PCC — Flush (solution/frequency/amount) _____

Dressing change (frequency) _____

☐ Implantable port — Flush (solution/frequency/amount) _____

If continuous infusion, frequency of needle change _____

☐ Central line — Flush (solution/frequency/amount) _____

Dressing change (frequency) _____

Child name _____ DOB _____ Child ID _____