



<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL KUMED 3901 Rainbow Boulevard Kansas City, Kansas 66160</p>	<p>Do not write in this box</p>  DT0017	<p>PATIENT LABEL</p>
PHYSICIAN'S ORDER FORM		

			<p>ORDERS ICU LEVEL I – PEDIATRIC BURN</p>
			<p>Criteria: • Over 10% TBSA • High Voltage Electrical Injury • Burn with Concomitant Trauma</p>
	1.		Reference: Herndon, D. (2007) Total Burn Care. 3 rd Ed. St. Louis: Elsevier Saunders
	2.		Allergies: _____ Weight _____ Kg Height _____ cm
	3.		Admit to: Burnett Burn Center
	4.		Attending Physician: _____ Pager _____ Resident/ NP: _____ Pager _____ Call Consult for Intensivist Concurrent Care with Pediatric Intensivist (On all Burn Pediatric ICU patients)
	5.		Diagnosis: _____ %TBSA(per burn diagram) <input type="checkbox"/> Inhalation Burn Injury
	6.		Burn Type: <input type="checkbox"/> Flame <input type="checkbox"/> Scald <input type="checkbox"/> Flash <input type="checkbox"/> Electrical <input type="checkbox"/> Chemical <input type="checkbox"/> Other _____
	7.		Condition: <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
	8.		Activity: <input type="checkbox"/> Full Spine precautions <input type="checkbox"/> Cervical Spine precautions <input type="checkbox"/> Bed rest <input type="checkbox"/> Stretcher chair/ wagon <input type="checkbox"/> Up to arms <input type="checkbox"/> Up ad lib
	9.		Specialty Bed: <input type="checkbox"/> Yes (requires Pulmonary Therapeutic Form/ Support Surfaces for Skin Integrity Form signed by Attending) <input type="checkbox"/> No
	10.		Diet: <input type="checkbox"/> NPO <input type="checkbox"/> Clear liquids <input type="checkbox"/> Regular <input type="checkbox"/> Advance to regular as tolerated <input type="checkbox"/> Other _____ Tube feeding: _____ <input type="checkbox"/> Full Strength <input type="checkbox"/> ½ Strength Start at _____ mL/hr initially. Increase by _____ mL every _____ hr to reach goal of _____ mL/hr Decrease by 20mL/hr if started on vasoactive drips
	11.		Nursing: <input type="checkbox"/> ECG <input type="checkbox"/> CVP every _____ hr(s) <input type="checkbox"/> Arterial line <input type="checkbox"/> Continuous SpO2 <input type="checkbox"/> intermittent SpO2:q _____ hr(s) <input type="checkbox"/> VS : every _____ hr(s) <input type="checkbox"/> I/O every hr <input type="checkbox"/> Bladder temperature every hr <input type="checkbox"/> Weight: <input type="checkbox"/> M-W-F <input type="checkbox"/> Daily <input type="checkbox"/> Peripheral Pulse Checks <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE every hour x 24 hours <input type="checkbox"/> NG tube /OG tube : Low intermittent suction <input type="checkbox"/> Small Bowel feeding tube Give Metoclopramide _____ mg (0.1mg/kg)IV X 1dose, May Repeat X1 in 10 min
	12.		DVT Prophylaxis <input type="checkbox"/> Intermittent pneumatic compression device <input type="checkbox"/> Thigh length <input type="checkbox"/> Bilateral <input type="checkbox"/> Right only <input type="checkbox"/> Left only <input type="checkbox"/> Calf length <input type="checkbox"/> Bilateral <input type="checkbox"/> Right only <input type="checkbox"/> Left only <input type="checkbox"/> Foot pumps <input type="checkbox"/> Bilateral <input type="checkbox"/> Right only <input type="checkbox"/> Left only <input type="checkbox"/> Other (specify) _____
	13.		Consult: • PT for strengthening, ROM, and mobility • OT for ROM, splints, ADL and scar management • Pediatric Social work: <input type="checkbox"/> Suspected abuse <input type="checkbox"/> Evaluation • Sunflower House for all suspected abuse <input type="checkbox"/> Nutrition <input type="checkbox"/> Child Life <input type="checkbox"/> Child Psychiatry <input type="checkbox"/> Child Education Specialist <input type="checkbox"/> Behavioral Pediatric <input type="checkbox"/> Pain Management <input type="checkbox"/> Other _____



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14.		<p>Respiratory Therapy :</p> <p><input type="checkbox"/> Mechanical Ventilation: Mode _____ Rate _____ Tidal Volume _____ Pressure Support _____ Positive end expiratory Pressure _____ FiO2 _____ Titrate for SpO2 _____</p> <p><input type="checkbox"/> Pressure Control Mode: Pressure Control (Peak Inspiratory Pressure) _____ cmH2O, OR</p> <p><input type="checkbox"/> Target Tidal Volume _____ Not to exceed _____ cmH2O</p> <hr/> <p><input type="checkbox"/> ABG 30 minutes after initiation of mechanical ventilation OR</p> <p><input type="checkbox"/> VBG 30 minutes after initiation of mechanical ventilation</p> <hr/> <p><input type="checkbox"/> Call physician if Airway Pressure Exceeds: _____</p> <p><input type="checkbox"/> Exempt from Weaning Protocol</p> <p>Oxygen Therapy:</p> <p><input type="checkbox"/> Nasal Canula _____ Liters/Minute <input type="checkbox"/> Mask _____ %FiO2 <input type="checkbox"/> Titrate Oxygen to keep SaO2 > _____ %</p> <p>Lung Expansion:</p> <p><input type="checkbox"/> IS X 10 q 1 hr. While Awake <input type="checkbox"/> Positive Expiratory Pressure _____</p> <p><input type="checkbox"/> Intermittent Positive Pressure Breathing _____ <input type="checkbox"/> Intrapulmonary Percussive Ventilation (IPV) _____</p> <p>Airway Clearance:</p> <p><input type="checkbox"/> Vibrating Positive Expiratory Pressure <input type="checkbox"/> Vibrating Vest <input type="checkbox"/> Postural Drainage and Clapping,</p> <p><input type="checkbox"/> Nasotracheal Suctioning _____ <input type="checkbox"/> Intrapulmonary Percussive Ventilation (IPV) _____</p> <p>Nebulized Medication Therapy for _____ every ____ hrs PRN</p> <p>Bronchodilator:</p> <p><input type="checkbox"/> Albuterol _____ mg every 4-6 hours prn (weight < 20 kg 2.5 mg albuterol in ~3 mL NS; Weight > 20 kg 5 mg albuterol in ~3 mL NS)</p> <p><input type="checkbox"/> Ipratropium _____ mg every 4-6 hours PRN (Usual dose 500 mcg, consider 250 mcg in infants)</p> <p><input type="checkbox"/> Levalbuterol _____ every _____ PRN (usual dose 0.63mg, Consider 0.31mg in infants)</p> <p><input type="checkbox"/> Racemic Epinephrine _____ every _____ PRN (0.25mL-0.5 mL in 3 mL NS)</p> <p><input type="checkbox"/> Other _____</p>
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15.		<p>Fluid Resuscitation:</p> <p>IV: Lactated Ringer's solution: 3-4mL x _____ Kg Body Weight x _____ Percent Burn = _____ mL/24hr Infuse _____ mL/hr x 8 hr, then _____ mL/hr x 16 hr (½ is given in the first 8 hours post-injury)</p> <p><input type="checkbox"/> Titrate to urine output _____ mL/hr</p> <p>IV Fluid Titration Protocol: If UO does not meet goal for 2 hours begin titration protocol and notify physician.</p> <ul style="list-style-type: none"> • Increase resuscitation fluids (non-glucose containing) by 10% of present rate. • Continue to increase in 10% increments q 1 hr when UO is not meeting goal. • Once goal UO met, maintain fluid at the set rate. • IF UO meets goal for 2 hrs, begin to titrate down in 10% increments. • Notify Critical Care Attending before bolus therapy is initiated. • If UO does not meet goal after 50% increase in crystalloids, see COLLOID ADMINISTRATION protocol (#17). <p>Maintenance fluid for children less than 2yrs old: D₅LR _____ mL/hr for 24 hours</p> <ul style="list-style-type: none"> • First 10kg: 100mL/kg over 24 hours • Second 10kg: 50mL/kg over 24 hours • Each Kg > 20kg: 20mL/kg over 24 hours
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16.		<p>Second day fluids: start date _____ time _____</p> <p><input type="checkbox"/> IV D₅½NS with _____ meq KCl/L @ _____ mL/hr</p> <p><input type="checkbox"/> _____</p>
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	17.	<p>Colloid Resuscitation (colloid should not be given earlier than 12 hours post-burn surgery)</p> <p><input type="checkbox"/> When Urine Output (UO) has not met goal after:</p> <ul style="list-style-type: none"> • a total of 50% increase in fluid rate and or serum albumin is < 2.5 gm/dL <p>Administer Albumin 25 gm / 100 mL according to weight below: (Weight (Kg) Albumin (gms))</p> <ul style="list-style-type: none"> • <20 kg 6.25 gm / 25 mL over 1 hour. • 20-40 kg 12.5 gm /50 mL over 1 hour. • >40 kg 25 gm /100 mL over 1 hour. <p>Repeat twice maximum for urine output < _____ mL/hr or Albumin < _____. If no results notify Attending</p>	
	18.	<p>Medication dosing for patients GREATER THAN 2 MONTHS OF AGE: Medication dosing wt: _____ (Consult Pediatric Reference for patients < 2mo)</p>	
	19.	<p><input type="checkbox"/> ** Administer medications via _____ tube (where dosage/liquid available)</p>	
	20.	<p>Maintenance Opioid</p> <p><input type="checkbox"/> Morphine Sulfate _____ to _____ mg IV every 1hr prn pain (0.05 to 0.1 mg/kg bolus, for infusions 0.1 mg/kg/hour as a starting dose)</p> <p><input type="checkbox"/> May give additional _____ mg every _____ mins, max dose _____ mg PRN for wound debridement/dressing change.</p>	
	21.	<p><input type="checkbox"/> Midazolam _____ to _____ mg IV every 1hr prn anxiety/agitation/sedation (recommend: 0.025-0.05mg/kg/dose for peds. > 6 mos.)</p>	
	22.	<p><input type="checkbox"/> Codeine Elixir 15mg/mL: _____ mg. po every 4-6hr prn pain (recommend: 0.5-1mg/kg/dose)</p>	
	23.	<p><input type="checkbox"/> Morphine Sustained Release <input type="checkbox"/> 15mg tab <input type="checkbox"/> 30mg tab <input type="checkbox"/> _____ po q8hr (scheduled) (recommend: 0.3-0.6mg/kg/dose every 12 hr)</p>	
	24.	<p><input type="checkbox"/> Oxycodone 5mg/Acetaminophen 325mg <input type="checkbox"/> 1 tab <input type="checkbox"/> 2 tab <input type="checkbox"/> 1-2 tab po every 4hr prn pain (based on Oxycodone component: recommend 0.05-0.15mg/kg/dose up to 5mg/dose)</p>	
	25.	<p><input type="checkbox"/> Acetaminophen _____ mg po/ _____ pr q 4 hr prn pain/discomfort/T>38.5°C (rec:10-15mg/kg/dose) (Total acetaminophen not to exceed 75mg/kg/24 hr= _____ mg/24 hr)</p>	
	26.	<p><input type="checkbox"/> Diphenhydramine <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg IV/po every 6hr prn pruritis (recommend: 0.5-1mg/kg/dose Maximum 5mg/kg/day)</p>	
	27.	<p>Patients > 12 years of age and ≥ 40 kg :</p> <p><input type="checkbox"/> Zolpidem (Ambien®) 5 mg po/ng QHS prn; may repeat x 1</p> <p>Patients < 12 years of age or < 40 kg:</p> <p><input type="checkbox"/> Chloral hydrate (20 mg/kg) _____ mg po/ng QHS prn; may repeat x 1</p> <p><input type="checkbox"/> Lorazepam (0.05 mg/kg) _____ mg po/ng QHS prn; may repeat x 1</p> <p><input type="checkbox"/> Diphenhydramine (0.5 mg/kg) _____ mg po/ng QHS prn; may repeat x 1</p>	
	28.	<p>Micronutrients: Patients < 3 years of age</p> <p><input type="checkbox"/> Pediatric multi-vitamin po/ng daily: <input type="checkbox"/> 1mL conc (<1yr old) <input type="checkbox"/> 2mL conc <input type="checkbox"/> 1 chew tab (1-3yr old)</p> <p>For patients with • >20% Total Body Surface Area burns, add:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ascorbic Acid 250mg po/ng bid <input type="checkbox"/> Zinc Sulfate 110 mg po/ng daily <input type="checkbox"/> Vitamin A 10,000 units po/ng Mon Wed Fri <input type="checkbox"/> Folic Acid 0.2 mg po/ng daily 	

<p>ICU LEVEL I – PEDIATRIC BURN</p>	<p>(Page 3 of 5)</p>
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29.	<p>Micronutrients: Patients > 3years of age</p> <p><input type="checkbox"/> Multi-vitamin po/ng daily <input type="checkbox"/> 1 vitamins/minerals tab <input type="checkbox"/> 5mL suspension <input type="checkbox"/> 2 chewable tab</p> <p>For patients with >20% Total Body Surface Area burns, add:</p> <p><input type="checkbox"/> Ascorbic Acid 250mg po/ng bid</p> <p><input type="checkbox"/> Zinc Sulfate 110 mg po/ng daily</p> <p><input type="checkbox"/> Vitamin A 10,000 units po/ng Mon Wed Fri</p> <p><input type="checkbox"/> Folic Acid 0.4 mg po/ng daily</p>
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30.	<p>Stress Ulcer Prophylaxis</p> <p>PO/NG: <input type="checkbox"/> Famotidine (0.5 mg/kg; max 20 mg) _____mg <input type="checkbox"/> PO <input type="checkbox"/> NG <input type="checkbox"/> daily <input type="checkbox"/> q 12 h</p> <p> <input type="checkbox"/> Lansoprazole (0.5 mg/kg; max 30 mg) _____mg <input type="checkbox"/> PO <input type="checkbox"/> NG <input type="checkbox"/> daily <input type="checkbox"/> q 12 h</p> <p>IV: <input type="checkbox"/> Famotidine (0.5 mg/kg; max 20 mg) _____mg IV <input type="checkbox"/> daily <input type="checkbox"/> q 12 h</p> <p> <input type="checkbox"/> Esomeprazole (0.67 mg/kg; max 40 mg) _____mg IV <input type="checkbox"/> daily <input type="checkbox"/> q 12 h</p>
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31.	<p>Bowel Regimen</p> <p><input type="checkbox"/> Senna</p> <p style="padding-left: 20px;">Hold for loose stools</p> <p><input type="checkbox"/> < 2 years old: 2.5 mL po/ng QHS</p> <p><input type="checkbox"/> 2 to < 6 years old: 3.75 mL po/ng QHS</p> <p><input type="checkbox"/> 6 to < 12 years old: 7.5 mL po/ng QHS</p> <p><input type="checkbox"/> ≥ 12 years old: 10 mL po/ng QHS</p> <p><input type="checkbox"/> Concentrated Milk of Magnesia po/ng q AM beginning post burn day 2, until first BM, then every other day</p> <p style="padding-left: 20px;">May hold if BM within 24 hour of dose</p> <p><input type="checkbox"/> < 2 years old: (0.17 mL/kg) _____mL</p> <p><input type="checkbox"/> 2 to < 6 years old: 5 mL</p> <p><input type="checkbox"/> 6 to < 12 years old: 7.5 mL</p> <p><input type="checkbox"/> ≥ 12 years old: 10 mL</p> <p><input type="checkbox"/> Bisacodyl suppository PR every day beginning post burn day 2, until first BM, then every other day</p> <p style="padding-left: 20px;">May hold if BM within 24 hour of dose</p> <p><input type="checkbox"/> < 2 years old: 5 mg</p> <p><input type="checkbox"/> 2 to < 12 years old: <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg</p> <p><input type="checkbox"/> ≥ 12 years old: 10 mg</p>
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32.	<p>Blood Glucose Management</p> <p>Finger Stick Blood Sugar (FSBS) every _____hr(s). Start dose at _____.</p> <p><input type="checkbox"/> Cover with Sliding Scale Regular Insulin. Call H.O. for FSBS < 70 or > 200mg/dL.</p> <p style="padding-left: 20px;">Sliding Scale: 0.1 units/kg _____units SQ for every 50 mg/dL > 150 mg/dL not to exceed 10 units</p> <p><input type="checkbox"/> Regular Humulin Insulin Drip (150 units/150 mL NS) 0.05 - 0.1 unit/kg/hour infusion</p> <p style="padding-left: 20px;">Titrate insulin drip to keep blood glucose between _____mg/dL (80-130)</p> <p>FSBS every hour until blood glucose is within ordered parameter for two consecutive hours, then every 2 hours & PRN</p> <p>Report FSBS < 70 mg/dL or > 200 mg/dL to physician</p>
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33.	<p>Tests: <input type="checkbox"/> Metabolic Cart every- Sunday</p> <p>Other: _____</p>
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