

KidSTOP Westover Hills Stone Oak **Outpatient Physician Order**

*Required Information

*Patient Name: _			*Weight: kg	
*Date of Birth: Date of Surgery			ry/Procedure:	
*Allergies:				
*Diagnosis:				
Lab □ Bilirubin (total and direct)	□ COVID-19 PCR □ ESR	□PT/PTT □RFP	Radiology CXR KUB Abd Flat & Upright	
□ Blood Culture	□Glucose	□ Strep A Antigen		
□ BMP	□hsCRP	□T4F/TSH	An appointment is required for the following:	
□BNP	□ Influenza A/BAg	☐ Troponin I	†US of:	
□ CBC w/Auto Diff	□ Lead	□ Tuberculosis	□†CT Scan of:	
□ CBC w/Man Diff	☐ Lipid panel	(QuantiFERON-TB Gold)	□†MRI of:	
□ CK	□Mg	□Urinalysis	Reason:	
□ CKMB □ CMP □ COVID-19 Antigen	(not included in CMP or BMP) □ Mono □ Newborn Screen	☐ Urine Culture ☐ I/O Cath ☐ Clean Catch ☐ Urine Drug Screen	Call 210.704.4100 to schedule US, CT or MRI. † These exams may require prior authorization depending on insurance coverage. Authorization is the responsibility of the PCP office.	
□ Other:			Ortho Splints Performed	
Other:			□ Right □ Left □ Arm □ Wrist □ Leg □ Ankle □ Preformed Wrist Splint □ Ankle Air Splint □ Arm Sling	
Medications and Interventions □ IV Hydration for hours (Maximum two hours. Please send patient before 3:00 p.m)			□ Post-Op Shoe □ Boot □ Crutches □ Walker Cardiopulmonary	
□Normal Saline or □Lactate Ringerscc/kg			□ EKG □ □	
total fluids over minutes may repeat X 1 Ceftriaxone IM mixed w/ 1% Lidocaine per manufacturer recommendations mg/kg			Discharge Criteria Vital signs within normal limits Void x1 Tolerates clear liquids w/o emesis LOC appropriate for developmental age Respiratory d/c criteria Good air exchange	
			If Discharge Criteria Not Met	
<u> </u>			□ Call Office Cell/Pager:	
Physician's Information *Physician Office Number:			□Other:	
*After Hours Number:			Patient Label	
*Physician Fax Numb	er:			
*_			Updated 052223	

LOCATIONS



