## CHRISTUS． CHILDREN＇S

＊Patient Name： $\qquad$ ＊Weight： $\qquad$ kg
＊Date of Birth： $\qquad$ Date of Surgery／Procedure： $\qquad$
＊Allergies： $\qquad$
＊Diagnosis：

| Lab |  |  |
| :---: | :---: | :---: |
| －Bilirubin | －COVID－19 PCR | םPT／PTT |
| （total and direct） | －ESR | －RFP |
| $\square$ Blood Culture | －Glucose | $\square$ Strep A Antigen |
| $\square B M P$ | $\square \mathrm{hsCRP}$ | －T4F／TSH |
| －BNP | QInfluenza A／BAg | －Troponin I |
| $\square C B C$ w／Auto Diff | $\square$ Lead | －Tuberculosis |
| $\square C B C$ w／Man Diff | $\square$ Lipid panel | （QuantiFERON－TB Gold） |
| 口CK | $\square \mathrm{Mg}$ | －Urinalysis |
| $\square C K M B$ | （not included | －Urine Culture |
| ロCMP | in CMP or BMP） | 口I／O Cath |
| －COVID－19 Antigen | $\square \mathrm{Mono}$ | $\square$ Clean Catch |
|  | －Newborn Screen | －UVine Drug Screen |

－0ther： $\qquad$
－0ther：
Medications and Interventions
םIV Hydration for $\qquad$ hours
（Maximum two hours．Please send patient before 3：00 p．m）
－Normal Saline or
$\square$ Lactate Ringers $\qquad$ $\mathrm{cc} / \mathrm{kg}$
$\qquad$ total fluids over $\qquad$ minutes $\qquad$ may repeat X1
$\square$ Ceftriaxone IM mixed w／1\％Lidocaine per manufacturer recommendations ＿mg Every 24 hours X $\qquad$ day Total Dose $\qquad$
$\square$ Heparin（ 10 units $/ \mathrm{ml}-5 \mathrm{ml}$ ） 50 units
$\square$ Heparin（ 100 units／ml -5 ml ） 500 units
－TPA per protocol（no later than 5：00 p．m．）
$\square 5$ units／ 0.1 ml Tuberculin PPD Intradermally X1
－Rabavert 2．5 IU／ML IM X1（initital dose give：＿＿＿）
$\square$ Day 3 ロDay 7 ロDay 14
$\square$
$\square$

## Physician＇s Information

Radiology
$\square$ CXR
An appointment is required for the following：
$\square+$ US of：
$\square+C T$ Scan of：
$\square+$ MRI of：－
Reason：－
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．

Ortho Splints Performed

$\square$ Right $\square$ Left $\square$ Arm $\square$ Wrist $\square$ Leg $\square$ Ankle
$\square$ Preformed Wrist Splint $\square$ Ankle Air Splint $\square$ Arm Sling
$\square$ Post－Op Shoe $\square$ Boot $\square$ Crutches $\square$ Walker

Cardiopulmonary
$\square$ EKG
ㅁ $\qquad$ $\square$ $\qquad$

## Discharge Criteria

$\square$ Vital signs within normal limits
$\square$ Void x1
－Tolerates clear liquids w／o emesis
－LOC appropriate for developmental age
$\square$ Respiratory d／c criteria
$\square G o o d$ air exchange
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## If Discharge Criteria Not Met

 －Call Office Cell／Pager：－0ther： $\qquad$

Patient Label
＊Physician Office Number：
＊After Hours Number：
＊Physician Fax Number： $\qquad$
＊Physician（print name）：

## ＊Signature：

＊Date：

## LOCATIONS



