

KidSTOP at C.O.P.S.

Outpatient Physician Order

Phone: 210.704.2587 • Fax: 210.703.8580 • Monday through Friday • 8:00 a.m. to 8:00 p.m.

Patient Name: _____ Weight: _____ kg

Date of Birth: _____ Date of Surgery/Procedure: _____

Allergies: _____

Diagnosis: _____

Lab: 210.704.2302

- | | | |
|---|--|--|
| <input type="checkbox"/> CBC w/diff | <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Blood Culture |
| <input type="checkbox"/> CBC w/man diff | <input type="checkbox"/> Urine Culture | <input type="checkbox"/> RSV Ag |
| <input type="checkbox"/> BMP/CMP | <input type="checkbox"/> I/Ocath | <input type="checkbox"/> Influenza A/BAg |
| <input type="checkbox"/> T4F TSH | <input type="checkbox"/> Clean Catch | <input type="checkbox"/> Culture of |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Medications and Interventions

- IV Hydration for _____ hours (maximum 2 hours)
- IV fluids: _____
- _____
- _____
- _____

Discharge Instructions

Physician's Information

Physician Office Number: _____

Physician Fax Number: _____

Physician (print name): _____

Signature: _____

Date: _____

Central Scheduling: 210.704.4100

Radiology: 210.704.2372

- CXR
- KUB
- Abd Flat & Upright
- *CT Scan of: _____
- *MRI of: _____
- *US of: _____
- _____
- _____
- _____
- Contrast Yes or No
- Reason: _____

* These exams may require prior authorization and scheduling, depending upon insurance coverage. Authorization is the responsibility of the PCP office.

Cardiopulmonary: 210.704.2264

- EKG
- _____
- _____

Discharge Criteria

- Vital signs within normal limits
- Void x1
- Tolerates clear liquids w/o emesis
- LOC appropriate for development age
- Respiratory d/c criteria
 - Good air exchange
- _____

If Discharge Criteria Not Met

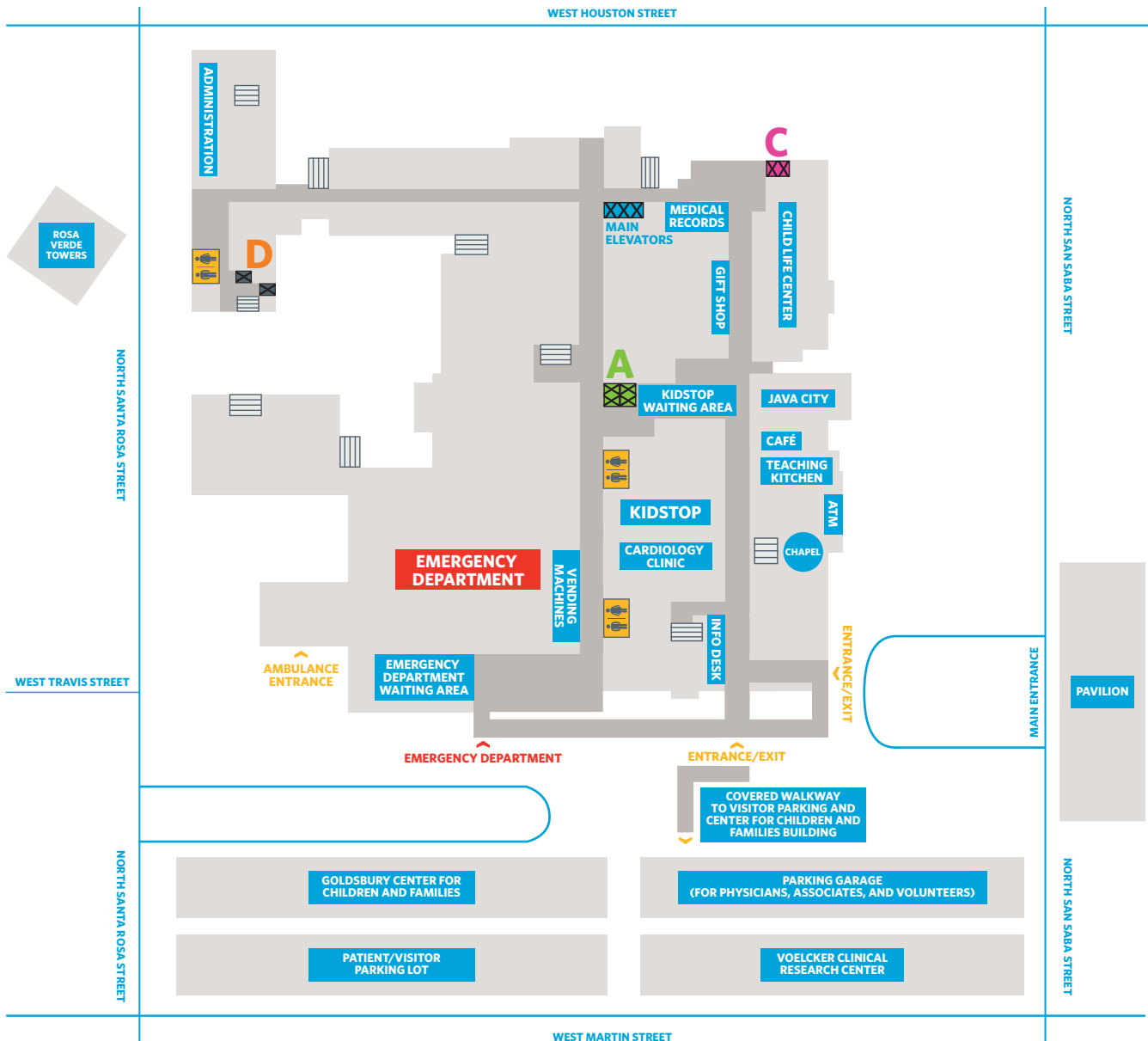
- Call Office Cell/Pager: _____
- Other: _____

Patient Label



The Children's Hospital
of San Antonio™

CHRISTUS Health



| | | |
|---|------------|----------------|
| Allergy, Immunology, and Rheumatology Clinics | 7th Floor | Main Elevators |
| Antepartum | 4th Floor | Main Elevators |
| Blood and Marrow Transplant | | |
| Center Outpatient Clinic | 7th Floor | Main Elevators |
| Cath Lab | 5th Floor | Main Elevators |
| Hematology/Oncology Outpatient | 7th Floor | Main Elevators |
| Hematology/Oncology Inpatient | 8th Floor | Main Elevators |
| Imaging | 2nd Floor | Elevator A |
| Labor and Delivery | 4th Floor | Elevator A |
| Laboratory | 3rd Floor | Main Elevators |
| Medical Care Unit | 10th Floor | Main Elevators |
| Mother-Baby Care | 9th Floor | Main Elevators |
| Neonatal Intensive Care Unit | 3rd Floor | Elevator A |
| Pediatric Intensive Care Unit | 5th Floor | Main Elevators |
| Ronald McDonald House | 4th Floor | Elevator C |
| Sleep Center | 9th Floor | Elevator C |
| Special Medicine Unit | 9th Floor | Main Elevators |
| Surgical Care Unit | 11th Floor | Main Elevators |
| Surgery Waiting Area | 2nd Floor | Elevators A |



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CHRISTUS Health

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