1719 Eighth Ave
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PHYSICIAN'S ORDERS FOR HOME PHOTOTHERAPY

Patient Name: ______________________ **Patient Phone #:** ________________ **Start of Care Date:** ____________

Date of Birth: ______________ **HT:** ________ **WT:** ________ **Allergies:** ______________________________

SOC Bilirubin: ___________ **Type of Therapy:** Biliblanket _________ Bilicrib _________ Doublebank _________

Transdermal BiliChek Lab Order: Skilled nurse to perform weight check and Bili level measurement per use of BiliChek (Infants with a bilirubin level of 18 or less). ______________________________
(frequency)

***Patient to have serum bilirubin lab performed if unable to retrieve level via BiliChek if total bilirubin level is greater than 18 or protective skin patch is removed or not intact.

-OR-

Serum Bilirubin Level Lab Order: Skilled nurse to perform weight check and obtain lab for bilirubin level.

____
(frequency)

Additional labs: ____

Call results to: ______________________________ **Phone #:** ______________________

Special Instructions:

____

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______________________________ ______________________________ **TORB / VORB**
Clinician Signature **Date/Time** (Circle)

______________________________ ______________________________
Physician Signature **Date/Time**

REVISED 04/30/2009
HHPOHMPHT