Cook Children's
Home Health

1719 Eighth Avenue
Fort Worth, TX 76110
Office: (682) 885-6294
Fax: (682) 885-8409

PHYSICIAN'S ORDERS FOR HOME HEALTH SERVICES

PATIENT: _____ **PATIENT PHONE#:** _____ **START OF CARE DATE:** _____

DATE OF BIRTH: _____ **HT:** _____ **cm** **WT:** _____ **kg** **ALLERGIES (OTC/Herbal):** _____

Respiratory Services Requested:

Oxygen Therapy: _____ Cardiac/Apnea Monitor: _____ Pulse Oximeter: _____ CPAP: _____ BiPAP: _____
Ventilator: _____ Suction Machine: _____ Cough Assist Device: _____ Nebulizer: _____ Other: _____

Oxygen Therapy:

Oxygen Equipment: Concentrator / Liquid Oxygen / Tanks Delivery Device: Nasal Cannula / Mask / Trach Collar
Flow Rate _____ Frequency _____ Humidification: Yes ____ No ____

Pulse Oximeter:

☐ Spot Check ☐ Continuous
High Limit _____ Low Limit _____ High Heart Rate _____ Low Heart Rate _____ Keep Sats Above _____%

Cardiac/Apnea Monitor:

High Heart Rate _____ Low Heart Rate _____ Apnea Delay _____ seconds
Frequency: Continuous / While Sleeping Other: _____

CPAP / BiPAP:

Expiratory Pressure Setting _____ Inspiratory Pressure Setting _____ Rate _____

Ventilator:

Mode _____ Breath Rate _____ Tidal Volume _____ Pressure Control _____ I-Time _____
Pressure Support _____ O2 % _____ Sensitivity _____ Mode _____ PEEP _____ LMV Alarm _____
High Pressure Alarm _____ Low Pressure Alarm _____ Frequency _____

Suction Machine:

Portable _____ Stationary _____
Catheter Type: Yankeur _____ Sleeved Catheter _____ Closed Catheter _____ Other: _____
Catheter Size _____

Cough Assist Device:

Exhale Pressure _____ Inhale Pressure _____ Expiratory Time _____ Inspiratory Time _____
Pause Time _____ Frequency _____ Sets _____ Repetitions _____

Nebulizer:

Nebulizer Machine _____ Supplies: Misty Nebulizer Kit _____ Aerosol Mask _____ Trach Collar _____

Other:

Aerochamber/Spacer _____ Flow Meter _____ PariNeb _____ Other: _____
Trach Type:_____ Trach Size: _____ Emergency Trach Type: _____ Emergency Trach Size: _____

Phototherapy:

Start of Care Bilirubin: _____ Date: _____

Type of Therapy: Biliblanket Crib Doublebank
(Circle One)

CCHH Nursing for Lab: Yes or No (Circle One)
Serum Bilirubin Level Lab Order: Skilled nurse to perform weight check and obtain lab for bilirubin level.
Additional Labs: _____

Enteral Therapy:

☐ Feeding Pump & Feeding Pump Supplies ☐ Formula: _____
NG Tube: Fr: _____ Length: _____
Type: ☐ Non-Weighted ☐ Weighted (To be changed/replaced in ER to confirm proper placement)
G-Button: Type: _____ Size: _____
Feeding Supplies: _____

Social Worker Consult: ☐ **Yes** ☐ **No**

Other DME:

Special Instructions:

_____

Physician Signature: _____ **Date/Time:** _____