



**PHYSICIAN ORDERS
FOR
CRITICALLY ILL NEONATE
0 TO 28 DAYS OF AGE
in the EMERGENCY DEPARTMENT**

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Patient Identification

Weight: _____ kg Length: _____ cm Allergies: _____

Initial on all lines applicable

INITIAL STABILIZATION AND MANAGEMENT:

- Place baby in warm environment. *Continuous temperature monitoring if rectal temp less than 36.5 °C or temperature instability*
- Cardiorespiratory monitoring with SpO₂ (Right hand)
- Suction nares and ensure patency. Apply O₂ as needed to keep sats \geq 92%. If RR <40 assist with CPAP
- Secure 2 PIVs. Send labs
- If HR <60 start PALS. IF HR >180 give NS bolus 10 mL/kg bolus over 10 min. If HR >220 consider SVT
- POCT glucose. If \leq 2.6 mmol/L give D10W (see Medications) and recheck glucose in 5 min
- Treat for sepsis with antibiotics (see Medications)

INVESTIGATIONS:

- Blood C&S, CBC & Diff, glucose, venous blood gas, lactate, electrolytes, Ca, Mg, urea, creatinine
- Bilirubin (if the infant is jaundiced)
- CXR

HYDRATION:

_____ IV Bolus _____ mL (10 mL/kg) of 0.9% NS over 10 – 30 min
 _____ IV D5W/0.9% NaCl at _____ mL/hr (*Neonates less than 3 days old should be maintained with D10W once stable*)
 _____ Other: IV _____ at _____ mL/hr

MEDICATIONS:

Hypoglycemia

_____ **D10W** _____ mL (5 mL/kg/dose) IV, followed by **D10W infusion** _____ mL/hr (4 mL/kg/hr)

Sepsis

_____ **Ampicillin** _____ mg (75 mg/kg/dose) IV

AND **Tobramycin OR Gentamicin** _____ mg (4 mg/kg/dose if 0-7 days, 5 mg/kg/dose if 8 – 28 days) IV

If suspected Meningitis add _____ **Cefotaxime** _____ mg (75 mg/kg/dose) IV

Respiratory

_____ Epinephrine 1 mg/mL (1:1000) (use injectable formulation): _____ mL by inhalation
 (Less than 10 kg dose = 3 mg (3 mL); Greater than or equal to 10 kg dose = 5 mg (5 mL))

Seizures

_____ **Lorazepam** _____ mg (0.1 mg/kg/DOSE) IV

Metabolic

_____ **Hydrocortisone** 25 mg IV push *For Congenital Adrenal Hyperplasia*

_____ **D10W Infusion** _____ mL/hr (6 mL/kg/hr) IV *For Inborn Error of Metabolism*

Duct-Dependent Cardiac Lesion

_____ **Alprostadil (prostaglandin) Infusion** _____ mcg/kg/min *Consult with tertiary center for dose*

PHYSICIAN SIGNATURE

PRINT NAME OF PHYSICIAN

DATE & TIME

NURSE SIGNATURE

PRINT NAME OF NURSE

DATE & TIME