



**CULLMAN**  
REGIONAL

## PHYSICIAN'S ORDERS

NAME:  
ROOM NO:  
(ADDRESS)  
HOSP. NO.  
PHYSICIAN

**Another brand of drug identical in form and content may be dispensed unless checked. ☐**

### Newborn Admission Order Set

Admit Inpatient

1. Admit to Newborn Nursery Service: Dr. \_\_\_\_\_. Notify MD of newborn admission.
2. Document admission weight, length, head circumference and graph.
3. Aquamephyton IM within 1 hour of birth: ☐  $\geq 1500$  gm, give 1 mg  
☐  $< 1500$  gm, give 0.5 mg
4. Eye Prophylaxis within 1 hour of birth: Erythromycin Ophthalmic Ointment OU.
5. Obtain consent for preservative free Hepatitis B Vaccine. Hepatitis B Vaccine 10 mcg IM x 1.
6. Rectal temperature, heart rate, respiratory rate on admission.
7. Assess and document axillary temperature, heart rate, respiratory rate, location and activity every 30 minutes until infant is stable for two consecutive hours.
8. Axillary temperature, heart rate, respiratory rate every 4 hours x 3, then every 8 hours until discharge.
9. Cord blood for RPR, ABO, Rh and Coombs. Collect if not obtained during delivery.
10. Maternal GBS Status: ☐ Positive ☐ Negative \*If positive, initiate Standing GBS MD orders\*
11. Glucose monitoring per order set for LGA, SGA, IDM, premature or for signs and symptoms of hypoglycemia.
12. Oxygen per NRP Guidelines for respiratory distress and notify Physician Stat.
13. Obtain urine CMV for SGA newborns in  $< 10^{\text{th}}$  percentile.
14. Bathe with mild soap when temp  $> 98^{\circ}\text{F}$ .
15. May manage infant in Mom's room as tolerated.
16. Note mothers HBSAg status and document. Notify MD Stat if mother is positive or unknown.
17. If positive Coombs, get baseline HCT, Total Serum Bilirubin, and Retic at 12 hours of age and then q 12 hours until discharge. Notify MD.
18. NAS scoring for maternal positive UDS. Notify MD.
19. If breastfeeding: Feed in delivery room and then on demand. Document efficacy of feeding and provide Mom with breast pump as needed.
20. If formula feeding: Feed on demand, document efficacy of feeding, and offer standard formula of physician or mother's preference. Do not change formula without consulting MD.

**MD Signature:** \_\_\_\_\_ **Date & Time:** \_\_\_\_\_

**Cullman Regional**

**Please use Ball Point Pen ONLY**

**Physician's Orders**

**DO NOT USE: U IU QD QOD MS MSO4 MgSO4**