Admit Orders to the Hospital:

ADCVANDIML-Call HO

A: Admit to (service: Glasgow, Lahey, Veasy, ENT, Neurosurgery etc.
   List Admitting Intern (Student if on Glasgow) and Pager number
   List Admitting Resident and pager number
   List Admitting Attending

D: Diagnosis
   List the main diagnosis and any other that are pertinent to the care of the patient

C: Condition
   This indicates to the nursing staff and PR folks how sick the patient is
   Serious, Guarded, Critical, Stable, not to be released etc.

V: Vitals
   This is how frequently YOU want vital signs checked.
   This can be every 15 minutes, hourly, every 4 hours, every 12 hours, daily or
   whatever you choose. If you put “per routine” you better know what that
   means.

A: Activity
   This refers to limitations on activity
   Bed rest, bed rest with bathroom privileges, crib and mothers arms, ad lib
   No restrictions – this directs many of the cares that the patient will receive.

N: Nursing
   What you want the nurses to routinely do
   Accurate input and output values, daily weight, calorie counts, CR
   (cardiorespiratory) monitor, pulse oxymetry, etc.

D: Diet
   What you want the patient to eat
   NPO (nothing per os – NO eating or drinking), per age (as long as you
   know what that means), 1000 calorie ADA (American dietary
   association), no added salt, whatever the special food that the parents are
   using etc.

I: IVF (intravenous fluids)
   The child may not need an IV, but if they do this line dictates what fluid to hang.
   You should indicate the fluid and the rate that it is to run
   i.e. D5 .2 NS + 20 mEq/L of KCl tra (to run at) 14 cc/hr
   YOU SHOULD KNOW WHY YOU ARE USING THIS FLUID AND
   HOW TO CALCULATE EVERY ASPECT OF THE ORDER
M: Medications
These are the medications the patient will be receiving
Include the name, dose, route and frequency
Oxygen is a medication! Just because it comes out of the wall does not mean it is routinely used. If you want the patient on oxygen list it here, how you want it delivered (mask, nasal cannula etc.).
At your stage of training you should not get into the habit of writing prn (as needed) orders. If a patient needs a medication YOU should evaluate that patient and determine for yourself if the order is needed. Later on when you have developed clinical acumen, you may be able to anticipate that certain medications will be needed based upon the natural history of the disease.

L: Labs
These are the labs that need to be drawn now and those that need to be obtained routinely. You should only order labs whose abnormal or normal results will change your treatment plan. Ordering a lab just because you want to see the result is poor form AND you may get an abnormal result and now YOU must explain why the result is abnormal.
You can also order other ancillary studies under this heading such as x-rays, ECG, EEG, etc. Whenever you order one of these studies you need to write down in the order sheet the indication for the study. Do not put “because I want it”.

Call HO: This section should be filled out on ALL patients and alerts the nursing staff to things that you really want to know about. The nurses are your eyes and ears while you are busy working up other patients, eating or sleeping. The nurses and ancillary personal should always be treated with the utmost respect.
THEY DO NOT WORK FOR YOU!
Temperature: > 38 C if patient < 6 months old
> 38.5 C if patient > 6 months old
Respiratory Rate: If the patient is not admitted with respiratory distress than any sustained rate (for > 5 minutes) that is over the upper limits of normal should be concerning. If the patient is admitted with respiratory distress, than you need to decide at what rate you would change your management plan. You will always want to be called if the rate is < 10/minute.
Oxygen Saturation: If you patient is on a pulse ox, you want to know if the saturation is < 88%. You also want to know if any increases in oxygen flow are made. An increase in need for supplemental oxygen is a sign of alveolar disease and need to be addressed immediately.
Heart Rate: You will want to be notified when the heart rate is sustained above a normal rate or above the patients’ normal rate. This will vary with age. You always want to know if the heart rate is < 60/minute.
Systolic Blood Pressure: The diastolic pressure is routinely abnormally low therefore you should want to know only about the SBP (the mean blood pressure is a calculated number [(SBP + 2*DBP)/3] so it may be low too). Here again choose a number that is abnormal for age or for the child (if
they are admitted for hypertension than you will constantly be called if you want to be notified if the SBP is above the upper limit of normal. You always want to be called if the SBP is below the lower limit of normal for age.

Urine output: Many children are admitted with poor oral intake and their dehydration may not be appreciated. Also patients with meningitis, brain injury or diabetes may develop diabetes insipidus or an osmotic diuresis. You want to know this. Normal urine output (UOP) for a child is 1 – 2 cc/kg/hr (normal for an adult is .5 – 1 cc/kg/hr). If a child is putting out more than 4 – 5 cc/kg/hr you want to know so that you can evaluate why this abnormally high UOP is occurring.

Always put down as the last line “Please call with any questions or concerns”

Sign your orders LEGIBLY and put your pager number after your signature.