Patient: Baby Benz	DOB: 4/8/XXXX	Age: 20 minutes old
Attending: Dr. Arc	Allergies	MR# 301-B
Diagnosis: Newborn	Gender: Male	Height: 20 inches Weight: 9lbs. 2 oz.

PATIENT INFORMATION

HISTORY OF PRESENT ILLNESS:

Apgar's: one minute 7, Five minutes 9

Infant presents to the nursery with respiratory distress.

PAST MEDICAL HISTORY:

None

SOCIAL HISTORY:

None

REPORT TO PARTICIPANTS:

Situation: Baby Benz was born 20 minutes ago and admitted to newborn nursery

Background: Patient was delivered via c/section at 37 weeks gestation; mother with a history of gestational Diabetes.

Assessment: Patient is well developed 9lb. 2 oz., 21 inch newborn whose APGAR score was 7 and 9.

Recommendations: Continue to monitor

History & Physical

none

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ADMIT / PHYSICIAN ORDERS

Day	Time	Complete top portion with each level of care change.
		☐ Outpatient Procedure:_____(procedure) for _____ (medical reason).
		☐ Place in Outpatient Observation Services for:
		X Admit as Inpatient for: Inpatient, Newborn Nursery Unit
Day	**Time**	**PHYSICIAN ORDER AND SIGNATURE**
	1215	Diet and Nutrition Upon completion of a normal assessment by the RN of the newborn following delivery, the Well Newborn Routine admission protocol may be initiated. 1. Breast or Formula feeding 2. Begin feeding as soon as infant is stable Medications 1. Hepatitis B vaccine: Recombivax 5 mcg (0.5 ml) or Engerix-B 10 mcg (0.5 ml) intramuscularly in the right anterior thigh (one time as soon as possible following transfer to nursery). 2. If HBsAg positive mother: Give HBIG 0.5 ml IM as soon as possible (within 12 hours of delivery). 3. Aquamephyton, 1 mg (0.5 ml) IM within 1 hour after delivery 4. Erythromycin eye ointment OU x1 after delivery. Lab and Diagnostic Studies 1. Metabolic screening prior to discharge. 2. Capillary blood sugar monitoring per protocol 3. Transcutaneous bilirubin reading and/or total serum bilirubin per Universal Screening Protocol 4. Cord Blood: a. If Rh negative, if blood type O, if antibody screen positive, or if unknown blood type- initiate cord blood studies b. If cord blood studies are not indicated, hold cord blood Monitoring 1. Rectal temperature, pulse, respirations and weight on admission 2. Axillary temperature with pulse and respirations every 30 min. x 4, the per routine 3. Suction as needed to keep airway clear 4. Oxygen free flow to maintain O2 stats over 95% by pulse oximetry for cyanosis and/or respiratory distress, notify physician, perform further assessment and transfer to higher level of care as needed.
PROVIDER SIGNATURE		*Dr. Arc*

Patient: Baby Benz | DOB: 4/8/XXXX | Age: 20 minutes old
Attending: Dr. Arc | Allergies | MR# 301-B
Diagnosis: Newborn | Gender: Male | Height: 20 inches Weight: 9lbs. 2 oz.

NURSING FLOW SHEET

DATE:					
VITAL SIGNS	TIME	0600	0800	1200	1600
	BLOOD PRESSURE				
	PULSE				
	RESP RATE				
	TEMP				
PAIN	SCORE				
	LOCATION				
	CHARACTER				
RESP	OXYGEN				
	OXIMETER				
NUTR	DIET / % EATEN				
	SUPP FEEDING				
INTAKE	PO				
	IV				
OUTPUT	URINE				
	DRAINS				

PROBLEM / EVENT DOCUMENTATION	
DATE / TIME	.
SIGNATURE	

Patient: Baby Benz	DOB: 4/8/XXXX	Age: 20 minutes old
Attending: Dr. Arc	Allergies	MR# 301-B
Diagnosis: Newborn	Gender: Male	Height: 20 inches Weight: 9lbs. 2 oz.

MEDICATION ADMINISTRATION RECORD Pg. 1

SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
Hepatitis B vaccine: Recombivax 5 mcg (0.5 ml) or Engerix-B 10 mcg (0.5 ml) intramuscularly in the right anterior thigh (one time as soon as possible following transfer to nursery) If HBsAg positive mother: Give HBIG 0.5 ml as soon as possible (within 12 hours of delivery).	1500	
Phytonadione (Vitamin K) 1 mg (0.5 ml) IM within 1 hour after delivery	1215 JP	
Erythromycin eye ointment OU x 1 after delivery	1215 JP	

SIGNATURE	INTLS	SIGNATURE	INTLS
JPatrick, RN	**jp**		

Patient: Baby Benz | DOB: 4/8/XXXX | Age: 20 minutes old
Attending: Dr. Arc | Allergies | MR# 301-B
Diagnosis: Newborn | Gender: Male | Height: 20 inches Weight: 9lbs. 2 oz.

MEDICATION ADMINISTRATION RECORD Pg. 2

NON – SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**

SIGNATURE	INTLS	SIGNATURE	INTLS

LAB STUDIES & DIAGNOSTICS

CHEMISTRIES		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Sodium (NA+)	135-145 mEq/L	
Potassium (K+)	3.5 -5.0 mEq/L	
Chloride (CL-)	100-108 mEq/L	
Carbon Dioxide (C02)	24-30 mEq/L	
Magnesium (Mg++)	1.5-2.0 mEq/L	
Glucose	70-110 mg/dL	
Calcium (Ca++)	8.5-10.5 mg/dL	
Phosphorous (P04	2.6-4.5 mg/dL	
Blood Urea Nitrogen (BUN)	8-25 mg/dL	
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	
Osmolality	280-295 mOsm/kg	
Albumin	3.5-4.8 g/dL	
Pre-Albumin	19-38 mg/dL	
Ammonia	15-56 ug/dL	
Bilirubin	0.3-1.0 mg/dL	
Conjugated (Direct) Bilirubin	0-0.2 mg/dL	
Alk Phos	25-100 u/L	
AST	Male: 14-20 u/L Female: 10-36 u/L	
ALT	10-35 u/L	
Amylase	25-125 u/L	
Lipase	10-140 u/L	

LAB STUDIES & DIAGNOSTICS

Arterial Blood Gases		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
pH	7.35-7.45	
$PaC0_2$	35-45 mmHg	
$Pa0_2$	>80 mmHg	
$Sa0_2$	>94%	
HCO_3	22-26 mEq/L	

LAB STUDIES & DIAGNOSTICS

HEMATOLOGY		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Red Blood Cells (RBC)	Males: 4.5-5.3 million /mm^3 Females: 4.1-5.1 million/mm^3	
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	
Hemoglobin (HgB)	Males: 13.0-18.0 g/100 ml Females: 12-16 g/100 ml	
White Blood Cells (WBC)	4,500-11,000/mm^3	
Platelets (Plt)	140-400 X 103 mm^3	
MCV	80-100	
MCH	27-33	
Retic count	0.5-2.5%	

LAB STUDIES & DIAGNOSTICS

CARDIAC MARKERS		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**

COAGULATION		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Prothrombin Time (PT)	Control 11.2-13.2 (+/-2 seconds)	
Partial Prothrombin Time (PTT)	22.1-34.1 seconds activated	
INR	1-2	

LAB STUDIES & DIAGNOSTICS

XRAY

STAT Lab Results

Laboratory Results		
Lab Test	**Normal Range**	**Patient Value**
DDimer	**<250**	

STAT Lab Results

Test	Results
VQ Scan	

The following is the form of a "Declaration," provided for under Nevada Statues:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment. I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration . . . . . |_____|

Signed this _____ day of _____, 20_____.

Signature: _____
Address: _____
_____
_____

The declarant voluntarily signed this writing in my presence.

Witness: _____
Address: _____
Witness: _____
Address: _____

The following is the form of a "Durable Power of Attorney for HealthCare Decisions" provided for under Nevada Statute:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS
WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for HealthCare. Before executing the document you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. The power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.
3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior Durable Power of Attorney for Health Care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, _____(insert your name) do hereby designate and appoint:
Name:
Address:
Telephone Number:
as my attorney-in-fact to make health care decisions for me as authorized in this document.
(Insert the mane and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)
In exercising the authority under this Durable Power of attorney for HealthCare, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

_____

_____