KidSTOP

Order Written:
Date: _____
Time: _____

Outpatient Physician Order

Phone: 210.704.2587 • Fax: 210.704.2868 • Monday through Friday • 8:00 a.m. to 6:00 p.m.

Patient Name: _____ Weight: _____ kg
Date of Birth: _____ Date of Surgery/Procedure: _____
Allergies: _____
Diagnosis: _____

Lab: 210.704.2302

- ☐ CBC w/diff
- ☐ CBC w/man diff
- ☐ BMP/CMP
- ☐ T4F TSH
- ☐ Newborn Screen
- ☐ *COVID PCR Test
  - ☐ Rapid PCR (in-house)
  - ☐ Send out PCR
- ☐ Urinalysis
- ☐ Urine Culture
  - ☐ I/Ocath
  - ☐ Clean Catch
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Blood Culture
- ☐ RSV Ag
- ☐ Influenza A/BAg
- ☐ Culture of _____
- ☐ _____
- ☐ _____

*Is patient symptomatic? ☐ No ☐ Yes, then call KidSTOP at 210.704.2587 to alert staff. Have patient call KidSTOP upon their arrival at 210.704.2587 so they can be escorted to designated area.

Medications and Interventions

- ☐ IV Hydration for _____ hours (maximum 2 hours and send patient before 5 PM)
  - ☐ Normal Saline or ☐ Lactate Ringers _____ cc/kg
  - _____ total fluids over _____ minutes _____ may repeat X 1
- ☐ Ceftriaxone IM mixed w/ 1% Lidocaine per manufacturer recommendations
  - _____ mg/kg Every 24 hours X _____ day
- ☐ Heparin 500 IV per port flush
- ☐ Heparin 50 units IV for PICC lines (per home health or parents dose)
- ☐ TPA per protocol (no later than 5 PM)
- ☐ _____
- ☐ _____
- ☐ _____

Ortho Splints Performed

☐ Wrist ☐ Ankle ☐ Boot ☐ Post-Op Shoe (foot/toe problems)

Please choose, if needed:

☐ Air Splint ☐ w/Crutches ☐ No Crutches ☐ Walker

Physician's Information

Physician Office Number: _____
Physician Fax Number: _____
Physician (print name): _____
Signature: _____
Date: _____

Central Scheduling: 210.704.4100

Radiology: 210.704.2372

☐ CXR ☐ KUB ☐ Abd Flat & Upright

- ☐ **CT Scan of: _____
- ☐ **MRI of: _____
- ☐ **US of: _____
- ☐ _____
- ☐ _____
- ☐ Contrast ☐ Yes or ☐ No
- ☐ Reason: _____

** These exams may require prior authorization and scheduling, depending upon insurance coverage. Authorization is the responsibility of the PCP office.

Cardiopulmonary: 210.704.2264

☐ EKG ☐ _____ ☐ _____

Discharge Instructions

_____
_____
_____

Discharge Criteria

- ☐ Vital signs within normal limits
- ☐ Void x1
- ☐ Tolerates clear liquids w/o emesis
- ☐ LOC appropriate for developmental age
- ☐ Respiratory d/c criteria
  - ☐ Good air exchange
- ☐ _____

If Discharge Criteria Not Met

- ☐ Call Office Cell/Pager: _____
- ☐ Other: _____

Circumcision

☐ Infant must be <10 lbs. and <30 days old
Referring physician must provide patient demographics and clinical notes

Patient Label

The Children's Hospital of San Antonio™
CHRISTUS Health

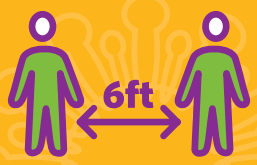
Updated 9/1/2021

WHAT WE ARE DOING TO KEEP YOU SAFE:

MASKS REQUIRED
(age 2 and older)

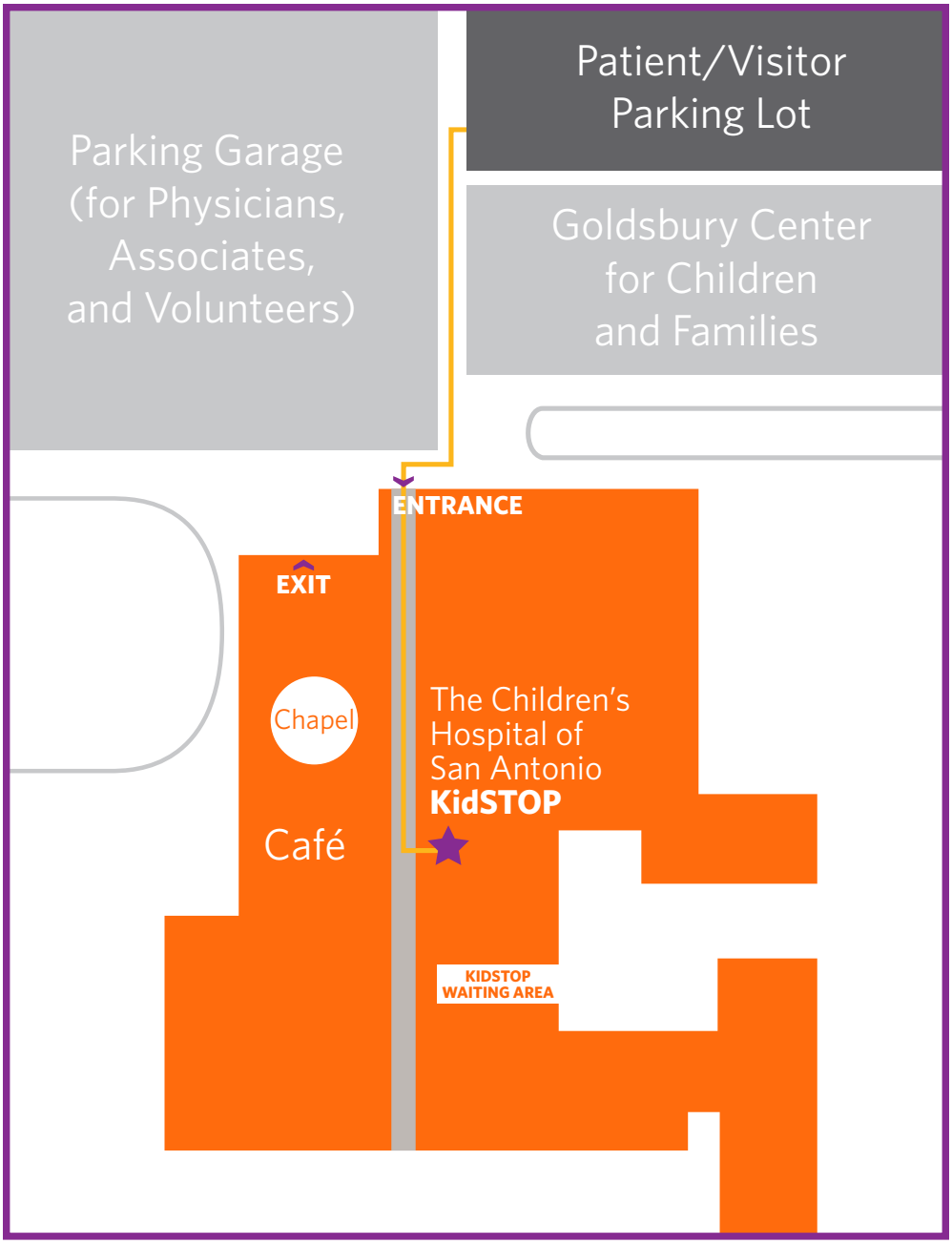
HEALTH SCREENING

HANDWASHING STATIONS



SOCIAL DISTANCING

LIMITED VISITORS
Only one parent/ caregiver allowed.
No siblings allowed.



KidSTOP Information:

Location: 333 North Santa Rosa Street • San Antonio, Texas 78207

Hours: Monday through Friday • 8:00 a.m. to 6:00 p.m.

Genetic Testing: Monday through Thursday

Circumcision Clinic: Wednesday • 8:00 a.m. to 12:00 p.m.

Phone: 210.704.2587

Fax: 210.704.2868

chofsa.org

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