# NORTH CAROLINA BAPTIST HOSPITAL
## PHYSICIAN ORDER FORM

**PHYSICIANS:** All orders should be written generically and using the Metric System; include the physician's signature, PRINTED name, ID Number, beeper number and the date/time. A generically and therapeutically alternative drug as approved by the P & T Committee may be dispensed unless the order is specifically designated "Dispense as Written."

Form Approved by Hospital Forms Committee: ___________ Rev. 1/2010

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**FAX**

**TITLE:** PEDIATRIC BEHAVIORAL HEALTH ADMISSION ORDERS  page 1 of 2

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
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</table>

(PLEASE CIRCLE OR CHECK APPROPRIATE ORDERS AND FILL IN BLANKS AS NEEDED)

**DIAGNOSIS:**

<p>| | |</p>
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<table>
<thead>
<tr>
<th>ALLERGIES:</th>
</tr>
</thead>
</table>

1. Admit to:  
- [ ] Child/Adolescent Inpatient  
- [ ] 23 Hour Triage/Observation

2. Condition:  
- [ ] Good  
- [ ] Fair  
- [ ] Serious  
- [ ] Critical

3. Status:  
- [ ] Voluntary  
- [ ] Involuntary (requires Court papers)

4. Vital Signs:  
- [ ] Routine (daily)  
- [ ] BID  
- [ ] TID  
- [ ] Orthostatic BP x 24 hours or [ ] x 48 hours

5. Precautions:  
- [ ] Suicide  
- [ ] Seizure  
- [ ] Elopement  
- [ ] Assault  
- [ ] Fall

6. Privileges:  
- [ ] No privileges

7. Observation:  
- [ ] Routine (q 30 min.)  
- [ ] Close Observation (q 15 min.)  
- [ ] 1:1 (continuous)

8. Psychological Assessments:  
- [ ] Beck Depression Inventory II (BDI-II)  
- [ ] Substance Abuse Workbook  
- [ ] Iowa Connors Rating Scale

9. Diet:  
- [ ] Pediatric Select (1-4 yrs)  
- [ ] Pediatric Select (5 yrs plus)  
- [ ] Other (specify): ________

- [ ] Nutrition Consult  
- [ ] Eating Disorder Protocol

Pediatric Consistent CHO:  
- [ ] 115g (800-1000 cal)  
- [ ] 175g (1200-1500 cal)  
- [ ] 215g (1600-1800 cal)

- [ ] 275g (2000-2400 cal)  
- [ ] 375g (2600-3000 cal)  
- [ ] 425g (3200-3600 cal)

10. Labs:  
- [ ] CBC w/diff  
- [ ] CMP  
- [ ] BMP  
- [ ] Lipid Profile  
- [ ] RPR  
- [ ] Serum Preg.

- [ ] TSH  
- [ ] UA  
- [ ] UDS

11. Serum Levels:  
- [ ] Carbamazepine  
- [ ] Lithium  
- [ ] Valproic Acid  
- [ ] Phenytoin

- [ ] Tricyclic (specify): ____________  
- [ ] Other (specify): ____________

---

**DATE:**  
**TIME:**

Physician Computer ID #  
Physician SIGNATURE:  
PRINT Physician NAME:  
Beeper #:

Unit Secretary SIGNATURE:  
TIME Sent to Pharmacy:  
RN SIGNATURE:
### NORTH CAROLINA BAPTIST HOSPITAL
### PHYSICIAN ORDER FORM

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Form Approved by Hospital Forms Committee: ________________  Rev. 1/2010

**FAX**  TITLE: PEDIATRIC BEHAVIORAL HEALTH ADMISSION ORDERS  page 2 of 2

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</table>

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<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>ALLERGIES</th>
</tr>
</thead>
</table>

12. Radiology: 
- [ ] CXR
- [ ] Other X-Ray (specify): __________
- [ ] Brain CT w/out contrast
- [ ] Brain PET Scan
- [ ] Brain MRI w/contrast
- [ ] Brain MRI w/out contrast
- [ ] Brain SPECT Scan
- [ ] Other Radiography (specify):

13. Cardiology: 
- [ ] EKG (reason): __________
- [ ] Echocardiogram (reason):

14. Diagnostic Neurology: 
- [ ] EEG
- [ ] Awake (Sleep Deprived)

15. Recreation Therapy: 
- [ ] Evaluation/Treatment Requested

16. Smoking Cessation Advice/Counselling: (if patient has smoked within the last year):
- [ ] Patient Education.
- [ ] Administer Fagerstrom Test for Nicotine Dependence.

17. PRN Medications: 
- [ ] Acetaminophen drops ______ (15 mg/kg/dose) PO q 4 hours prn for H/A, fever, pain.
  - [ ] Acetaminophen ______ (325 mg or 650 mg) PO q 4 hours prn for H/A, fever, pain.
    - (maximum dose 650 mg; maximum/day 4 gm).
- [ ] Ibuprofen suspension ______ (7.5 mg/kg/dose) PO q 6 hours prn for pain.
- [ ] Ibuprofen ______ (200 mg or 400 mg) PO q 6 hours prn for pain.
- [ ] Cepacol Lozenges 1 PO q 2 hours prn for sore throat.
- [ ] Aluminum Hydroxide/Magnesium Hydroxide (Maalox) ______ (15 ml or 30 ml) PO q 4 hrs prn for dyspepsia.
- [ ] Guaiifenesin cough syrup ______ (100 mg or 200 mg or 300 mg) PO q 4 hours prn for cough.

18. [ ] Continue Home Medications as listed below: (dose, route, and frequency).

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
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</table>

Physician Computer ID #  | Physician SIGNATURE:  | PRINT Physician NAME:  |
<table>
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<tr>
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<tbody>
<tr>
<td>________________________</td>
<td>_______________________</td>
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</tbody>
</table>

Beeper #: _________________________

Unit Secretary SIGNATURE:  | TIME Sent to Pharmacy:  | RN SIGNATURE:  |
|---------------------------|-------------------------|------------------|
| _________________________|_______________________|_________________

(Rev. 8/9/07)
North Carolina Baptist Hospital

SUICIDE SCREENING TOOL

Check one: □ Admission Date/Time: ________ □ Discharge Date/Time: ________ □ Consult Date/Time: ________

Directions:
1. Assess each key factor and circle the number in the bottom of each box that corresponds to the descriptor that BEST describes the patient.
2. Add the points for each checked item to obtain the total score.
3. Note physician's subjective risk appraisal (page 2).

<table>
<thead>
<tr>
<th>KEY FACTORS</th>
<th>Yes</th>
<th>2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Admission Precipitated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Suicide Attempt?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Attempt History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past attempts of high lethality</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past attempts of low lethality</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No previous attempts</td>
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<td>0</td>
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<tr>
<td>Suicidal Ideation</td>
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<tr>
<td>Constant suicidal thoughts</td>
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<tr>
<td>Intermittent or fleeting suicidal</td>
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<tr>
<td>thoughts</td>
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<tr>
<td>Denies current suicidal thoughts</td>
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<td>0</td>
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<tr>
<td>Suicide Plan</td>
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<tr>
<td>Has plan with actual OR</td>
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<tr>
<td>potential access to planned method</td>
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<tr>
<td>Has plan without access to planned method</td>
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<tr>
<td>No plan</td>
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<tr>
<td>Plan Lethality</td>
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<tr>
<td>Highly lethal plan (e.g., gun,</td>
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</tr>
<tr>
<td>hanging, jumping, carbon</td>
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<tr>
<td>monoxide)</td>
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<tr>
<td>Moderate lethality of plan</td>
<td></td>
<td>1</td>
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<tr>
<td>Low lethality of plan (e.g., biting,</td>
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<tr>
<td>head banging, superficial</td>
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<tr>
<td>scratching, pillow</td>
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<tr>
<td>over face, holding breath)</td>
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<tr>
<td>Safety Plan Agreement</td>
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<tr>
<td>Unwilling OR unable to agree due to</td>
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<tr>
<td>impaired reality testing (e.g.,</td>
<td></td>
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<tr>
<td>delusions, hallucinations,</td>
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<tr>
<td>dementia, delirium, dissociation,</td>
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<tr>
<td>dual diagnosis)</td>
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<tr>
<td>Patient is ambivalent and/or</td>
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<tr>
<td>guarded</td>
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<tr>
<td>Reliably agrees</td>
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<tr>
<td>Current Morbid Thoughts</td>
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<tr>
<td>(e.g., reunion fantasies,</td>
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<tr>
<td>preoccupation with death)</td>
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<tr>
<td>Constantly</td>
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<tr>
<td>Frequently</td>
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<tr>
<td>Rarely</td>
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<tr>
<td>Elopement Risk</td>
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<tr>
<td>High risk</td>
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<tr>
<td>Moderate risk</td>
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<tr>
<td>Low risk</td>
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<td>0</td>
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<tr>
<td>Symptoms (circle all that apply)</td>
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</tr>
<tr>
<td>hopelessness, helplessness,</td>
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<tr>
<td>anhedonia, guilt/shame,</td>
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<tr>
<td>anger/rage, anxiety, insomnia,</td>
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<tr>
<td>agitation, impulsivity</td>
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<tr>
<td>5 - 6 symptoms present</td>
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<td>2</td>
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<tr>
<td>3 - 4 symptoms present</td>
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</tr>
<tr>
<td>0 - 2 symptoms present</td>
<td></td>
<td>0</td>
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</tbody>
</table>

SCORING KEY:
10 or higher = Imminent Risk (consider 1:1)
4 - 9 = Moderate Risk (consider q 15 minute observation)
0 - 3 = Low Risk (consider q 30 minute observation)

Total Score: ______________________ (pg 1 of 2)

Physician's signature: ________________________________

Chart Copy

(MR 12/07)
Physician's Subjective Appraisal of Risk (check one):
☐ Patient replies not trustworthy; several non-verbal cues.
☐ Patient replies questionably; trustworthy; at least 1 non-verbal cue.
☐ Patient replies appear trustworthy.

Family History of Suicide? ☐ Yes ☐ No
List family members: ___________________________ ___________________________
                                ___________________________ ___________________________
                                ___________________________ ___________________________

Protective Factors (check all that apply):
☐ Successful past responses to stress ☐ Positive coping skills
☐ Spirituality/religious beliefs ☐ Frustration tolerance/optimism
☐ Capacity for reality testing ☐ Children or pets in the home
☐ Positive therapeutic relationships ☐ Sense of responsibility to family
☐ Social supports/connections ☐ Agrees to treatment plan and follow up

Others: ________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

High Risk Diagnoses (check all that apply).
☐ Depression/ Bipolar Disorder ☐ Schizophrenia ☐ Personality Disorder
☐ Dual Diagnosis ☐ Chronic Pain ☐ HIV/AIDS
☐ Cardiovascular Disease ☐ Epilepsy ☐ Multiple Sclerosis
☐ Neuropsychiatric Disorders ☐ Cancer

Comments:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

(Pg 2 of 2)