**UMC Health System**

# NICU DISCHARGE SOCIAL SERVICES PLAN

**Patient Label Here**

**PHYSICIAN ORDERS**

**Diagnosis** _____

**Weight** _____ **Allergies** _____

**Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.**

| ORDER | ORDER DETAILS |
|---|---|
| | **Consults/Referrals** |
| | **Social Services for DME for Home (Bivona Trach Supplies (NICU))**<br>☐ Spec Inst: ***See Order Comments***<br>Trach Cleaning kits: 1 box/month<br>Trach Collar ties (Velcro): 1 box/month<br>Sterile Water bottles (1L): 4 bottles/month<br>Q-Tips: 1 box/month |
| | **Social Services for DME for Home (Broviac Supplies (NICU))**<br>☐ T;N, Spec Inst: ***See Order Comments***<br>Heparin Lock Flush 10 units/mL (10 mL syringe)<br>Alcohol and Betadine Swab<br>Clave Needleless Connector<br>Central Line Dressing Tray<br>Chlorahexadine Swab<br>Sterile Saline<br>Biopatch<br>Sterile Gloves<br>Clean Gloves<br>3 mL Syringes |
| | **Social Services for DME for Home (Suction Supplies (NICU))**<br>☐ Spec Inst: ***See Order Comments***<br>Sterile Suction Kit: 2 boxes/month<br>Sterile saline squirts (3 mL): 1 box/month |
| | **Social Services for Home Enteral Feeding (G-Button/NG Supplies (NICU))**<br>☐ Additional Instr: Gtube kit and tubing, Spec Instr: ***See Order Comments***<br>Kangaroo Infusion pump: 1<br>Kangaroo Pump feeding bag: 1 box/month<br>Barrel Syringes (60mL): 2<br>Sterile Water (1L bottles): 1 month supply |
| | **Social Services for DME for Home (Ostomy Supplies (NICU))**<br>☐ Additional Instructions: ***See Order Comments***<br>NICU ostomy pouch <10 lbs (2pc, drain tap) #3778: x2 boxes/month<br>Stoma Powder #7906: x1 per month<br>Stoma Paste #839010: x1 per month<br>Adhesive Remover Spray #7737: x1 per month<br>No-sting Skin Prep Wipes #59420600 x1 per month<br>Continued on next page.... |

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

**Physician Signature**: _____ **Date** _____ **Time** _____

**UMC Health System**

# NICU DISCHARGE SOCIAL SERVICES PLAN

**Patient Label Here**

**PHYSICIAN ORDERS**

**Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.**

| ORDER | ORDER DETAILS |
|---|---|
| | |
| | **Social Services for CPS Call Follow-Up**<br>☐ T;N |
| | **Social Services for DME for Home**<br>☐ T;N, Nebulizer w/tubing & mask for Home Use ☐ T;N, Level III Pulse Oximetry Monitor for Home Use |
| | **Social Services for Home Health Care**<br>☐ T;N |
| | **Social Services for Home Oxygen Concentr (Social Services for Home Oxygen Concentrator)**<br>☐ T;N, O2 Flowrate: 0.1 LPM at 100%, Adhesive tape, Remover 1bx/month, Silk tape 1bx/month, Oxygen Concentrator, Pediatric Flowmeter, Portable Oxygen Tanks, Humidifier, Face to Face Done/See MD Progress Note |
| | **Social Services for Hospice to Evaluate (Social Services for Hospice to Evaluate and Admit)**<br>☐ T;N |
| | **Social Services for Outpatient Rehab Ser (Social Services for Outpatient Rehab Services)**<br>☐ Outpatient Occupational Therapy |
| | **Social Services for Outpatient Rehab Ser (Social Services for Outpatient Rehab Services)**<br>☐ Outpatient Physical Therapy |
| | **Social Services for Outpatient Rehab Ser (Social Services for Outpatient Rehab Services)**<br>☐ Outpatient Speech Therapy |
| | |

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

**Physician Signature**: _____ **Date** _____ **Time** _____