

UMC Health System PEDIATRIC INSULIN DOSING PLAN	Patient Label Here
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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

Patient Care

Pediatric Insulin Dosing Reference Order (Pediatric Insulin Dosing Reference Orders)
 See Reference Text.

POC Blood Sugar Check

<input type="checkbox"/> AC & HS	<input type="checkbox"/> AC & HS, and 0200
<input type="checkbox"/> AC & HS, and 0200 (no insulin coverage at 0200)	<input type="checkbox"/> q1h
<input type="checkbox"/> q2h	<input type="checkbox"/> q4h
<input type="checkbox"/> q6h	

POC Urinalysis Automated w/o Microscopy
 T;N, After each Void

Communication

Instruct Patient
 Instruct Patient On: Glucometer, Diabetic education

Medications

Medication sentences are per dose. You will need to calculate a total daily dose if needed.

pediatric diabetic kit
 1 ea, misc, kit, ONE TIME

Scheduled Insulin

insulin glargine
 units, subcut, inj, Daily, (Same as Lantus) units, subcut, inj, BID, (Same as Lantus)

insulin isophane (insulin NPH)
 units, subcut, inj, Daily units, subcut, inj, BID

Carbohydrate Adjusted Insulin

insulin aspart
 Carb Ratio (see order comments), subcut, inj, as needed, PRN other, (same as Novolog)
Consumed Carbohydrate Grams to Insulin Ratio
Breakfast: _____grams give _____units
Lunch: _____grams give _____units
Dinner: _____grams give _____units
Bedtime: _____grams give _____units

insulin aspart (insulin aspart Pen for Pediatric Education)
 Carb Ratio (see order comments), subcut, inj, as needed, PRN glucose levels - see parameters
Do Not Substitute - Needed for Education. A 4mm pen needle required for administration.
Consumed Carbohydrate Grams to Insulin Ratio
Breakfast: _____grams give _____units
Lunch: _____grams give _____units
Dinner: _____grams give _____units
Bedtime: _____grams give _____units

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TO Read Back Scanned Powerchart Scanned PharmScan

Order Taken by Signature: _____ Date _____ Time _____
Physician Signature: _____ Date _____ Time _____

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PHYSICIAN ORDERS

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ORDER	ORDER DETAILS
<input type="checkbox"/>	Insulin Autoantibody <input type="checkbox"/> Next Day, T+1;0300, Comment: Draw on day of discharge
<input type="checkbox"/>	Glutamic Acid Decarboxylase 65 Antibodie (Glutamic Acid Decarboxylase 65 Antibodies) <input type="checkbox"/> Next Day, T+1;0300, Comment: Draw on day of discharge
<input type="checkbox"/>	Zinc Transporter 8 Antibody <input type="checkbox"/> Next Day, T+1;0300, Comment: Draw on day of discharge
<input type="checkbox"/>	Celiac Disease Panel <input type="checkbox"/> Next Day, T+1;0300, Comment: Draw on day of discharge
<input type="checkbox"/>	Urinalysis <input type="checkbox"/> Urine, Next Day in AM, T+1;0300, Comment: Draw on day of discharge

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____

