Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4151; Fax: 207-768-4022
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Pediatric Oncology, **Brewer**
Phone: 207-973-7572; Fax: 207-973-9741
☐ NL Pediatric Sedation, EMMC, **Bangor**
Phone: 207-973-8758; Fax: 207-973-9583
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OUTPATIENT GROWTH HORMONE TESTING - PEDIATRIC

DIAGNOSIS: _____ **ICD10:** _____**Weight**_____**kg**

SCHEDULING

Testing to be done first thing in the morning

PREPARATION

☐ NPO *except for sips of water*

☐ NPO *except for sips of water; May take regularly prescribed medications prior to testing*

☐ Provider Communication *Patient to hold the following medications for testing:* _____

NURSING

NURSING: Notify Lab of Growth Hormone Testing. Notify Lab of potential need to coordinate with Phlebotomy for Lab draws.

Vital Signs

☑ Vital signs (Frequent) Every 15 minutes X 4 after receiving clonidine (Catapres) and/or Sinemet, then Every 30 minutes until discharge

☐ *Glucose at baseline and 90 minutes post glucagon or* carbidopa/levodopa

☑ *Vital signs:* 1. Less than 6 years notify MD if BP is less than 70/50 mmHg
2. Greater than 6 years notify MD if BP is less than 80/50 mmHg
3. Notify MD if systolic or diastolic blood pressure drops more than 10 mmHg from start of test

☑ Sodium Chloride 0.9% (Bolus Infusion) 20 mL/kg = _____ mL (choose below), Soln, IV, Every 1 hour, PRN, Hypotension
_____ 250 mL _____500 mL _____ 750 mL _____1000 mL

Diet

☑ NPO except for sips of water throughout test. If the patient has had a SMALL snack prior to testing, it is okay to proceed

☑ Zofran (ondansetron) 0.15 mg/kg = _____mg (max dose 8 mg), Soln, IVP, Every 4 Hours, PRN, Nausea or Vomiting. notify provider if second dose is needed

IV Access

Lidocaine topical cream NOT recommended for patients less than 1 month of age

☑ Lidocaine 4% topical cream *1 APP, Cream, TOPICAL, PRN, PRN, Other(comment), Prior to Venipuncture*

☐ Saline Lock *Insert peripheral Saline Lock. Comments: Draw all labs from Saline Lock if able; Discontinue Saline Lock after therapy completed.*

☐ PICC Line *Routine PICC Line Care, labs and restoration*

☐ Porta cath / Central Access Device (Hickman, Triple lumen) *Porta cath/Central Access Device access, labs, restoration and de-access*

MEDICATION

1. Draw Baseline labs
2. Administer _____ after baseline labs have been drawn
3. Draw growth hormone at 30, 60, 90 and 120 minutes post _____
4. Administer _____
5. Draw growth hormone at 30, 60, 90 and 120 minutes post _____
6. End of test

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS

June 2024 (Header update)

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OUTPATIENT GROWTH HORMONE TESTING - PEDIATRIC

☐ clonidine (Catapres)
- ☐ *50 mcg, Tab, PO, ONCE, Patient weight 5 – 15 kg*
- ☐ *100 mcg, Tab, PO, ONCE, Patient weight greater than 15 – 25 kg*
- ☐ *150 mcg, Tab, PO, ONCE, Patient weight greater than 25 – 35 kg*
- ☐ *200 mcg, Tab, PO, ONCE, Patient weight greater than 35 – 49 kg*
- ☐ *250 mcg, Tab, PO, ONCE, Patient weight greater than or equal to 50 kg*

☐ arginine (R-Gene 10) *5 mL/Kg =* _____ *mL, Soln(10%), IV, ONCE, Infuse Over 30 Minutes,* ***Max dose 30 gm (300 mL)***

☐ Sinemet (carbidopa/L-dopa) 12.5mg/125mg, TAB, PO, ONCE, for patient Less than 15 kg

☐ Sinemet (carbidopa/L-dopa) 25mg/250mg, TAB, PO, ONCE, for patient Greater than 15 kg

☐ glucagon *0.03 mg/kg =* _____ *mg (max dose = 0.5 mg), IM, ONCE*

☐ glucagon *0.03 mg/kg =* _____ *mg (max dose = 0.5 mg), IVP, ONCE*

LABORATORY

**Grossly hemolyzed or lipemic specimens cannot be accepted*

Baseline Labs

☐ Growth Hormone 0 Minutes *BLOOD, Routine, ONCE*

☐ IGF-1 w/Calculated Z-score *BLOOD, Routine, ONCE*

☐ *IGF Binding Protein 3, Routine, Once*

☐ Thyrotropin (TSH) *BLOOD, Routine, ONCE*

☐ Other _____

Timed Study Labs

☐ Growth Hormone 15 Minutes *BLOOD, Timed Study, ONCE, 15 Minutes post*_____, *Start Date:* _____ *Time:* _____

☐ Growth Hormone 30 Minutes *BLOOD, Timed Study, ONCE, 30 Minutes post* _____, *Start Date:* _____*Time:* _____

☐ Growth Hormone 60 Minutes *BLOOD, Timed Study, ONCE, 60 Minutes post* _____, *Start Date:* _____ *Time:* _____

☐ Growth Hormone 90 Minutes *BLOOD, Timed Study, ONCE, 90 Minutes post* _____, *Start Date:* _____*Time:* _____

☐ Growth Hormone 120 Minutes *BLOOD, Timed Study, ONCE, 120 Minutes post* _____,*Start Date:* _____ *Time:* _____

☐ Growth Hormone 30 Minutes *BLOOD, Timed Study, ONCE, 30 Minutes post* _____,*Start Date:* _____*Time:* _____

☐ Growth Hormone 60 Minutes *BLOOD, Timed Study, ONCE, 60 Minutes post* _____, *Start Date:* _____*Time:* _____

☐ Growth Hormone 90 Minutes *BLOOD, Timed Study, ONCE, 90 Minutes post* _____, *Start Date:* _____*Time:* _____

☐ Growth Hormone 120 Minutes *BLOOD, Timed Study, ONCE, 120 Minutes post* _____, *Start Date:* _____ *Time:* _____

☐ Other: _____

☐ Growth Hormone *BLOOD, Timed Study, ONCE, Other, Start Date:* _____ *Time:* _____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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OUTPATIENT GROWTH HORMONE TESTING - PEDIATRIC

POST TESTING

☑ Diet *Pediatric Diet, Age appropriate, *AFTER final lab draw collected*

☑ Provider Communication *Discharge home when all following criteria met:*

1. *Final lab collected,*
2. *Patient has eaten, and*
3. *Vital Signs stable*

OTHER _____

_____

_____

_____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS