

Neonatal Hospice Referral Form

The following are required for infant admission to Nationwide Children's Hospital Hospice.

- Order to admit patient to hospice. Order form to be signed by physician and faxed to NCH Hospice. Order must read "Admit patient to hospice" and include infant's name and DOB.
- There must be a physician willing to sign the hospice "Certification of Terminal Illness" form. This form states that the patient will die within 6 months if disease follows normal progression.
- Ohio DNR form is not mandatory but is highly recommended. Please print and have physician fill out and sign. Please send a copy home with patient as well as faxing a copy to NCH Hospice.
- Patients must be discharged home with emergency comfort medications or with plans to get emergency medications in the home ASAP in event of pain and/or dyspnea. We recommend both Morphine and Ativan be available.

RECOMMENDED MORPHINE DOSE 0.3 mg/kg every 4 hours PRN pain/dyspnea

RECOMMENDED LORAZEPAM DOSE 0.05 mg/kg every 4 hours PRN agitation/dyspnea

Our hospice medical directors are able to assist with dosing recommendations and can be reached via pager # 614-690-0065. Often times community retail pharmacies do not carry liquid Morphine or Ativan concentrations. Two pharmacies that do are Nationwide Children's Hospital Outpatient Pharmacy 614-722-9199 and Uptown Pharmacy in Westerville 614-839-7227. Prescriptions for hospice patients can be faxed.

- Patient must have an attending physician who will follow in the community and is agreeable to being contacted by hospice team 24/7 to address patient needs. Often times the family's pediatrician is agreeable to taking this role. If this is not the case, please let us know and we can assist in finding physician coverage.
- Evidence of terminal illness must be provided to NCH Hospice Medical Director. Ex: Copy of echo results for baby with Hypoplastic Left Heart Syndrome or copy of genetics report for baby with Trisomy 13.

**PLEASE FAX ALL ORDERS, INFORMATION AND FORMS TO
NATIONWIDE CHILDREN'S HOMECARE AND HOSPICE AT 614-355-1111
ATTN:HOSPICE**



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FEEDING ORDERS

Bottle feeding Ad Lib

Breastfeeding Ad Lib

Tube Feedings

If Baby is being tube fed is family offering breast and or bottle first? Yes No

Oral Gastric Tube **or** Nasogastric Tube
Size: _____ French Tube

Bolus Feeds **or** Pump Feeds
Feed _____ mLs over _____ minutes every _____ hours.

Formula: _____

Mix per package instructions **or** Mix _____ ounces of water with _____ scoops of formula.

* Please send baby home with 2-3 days of formula. Hospice does not cover infant formula. If family is WIC (Women Infant Children) eligible, please set them up with an appointment as you would for a healthy baby.



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DNR INFORMATION

- Our team recommends that the baby goes home with an Ohio DNR form. This is a layer of protection for the family and the patient.
- We describe the form as a “tool” for the family.
- The DNR allows the family to dictate whether CPR and advanced life support is started, and if it is started, it allows the family to tell first responders/medical providers to stop.
- Sometimes in times of anxiety and crisis, 911 is called. This form will allow the family to have their wishes for comfort care followed.
- The DNR form can be revoked at any time.
- NO PARENT OR FAMILY MEMBER IS REQUIRED TO SIGN THE OHIO DNR FORM.
- We recommend the DNR-CC box (not the DNR-Arrest box) is checked as if it is the most appropriate for these hospice situations.



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Initial Hospice Physician Certification Of Terminal Illness

Patient Name: _____ MR#: _____
(last, first, middle initial)

Parent/Legal Guardian: _____

Patient Medicaid # (if applicable) _____

Initial Certification (90 Days) for the election period of: _____ through _____

Primary diagnosis: _____

Having reviewed this patient's care and the course of his/her illness, I certify that this patient's medically predictable life expectancy is (6) months or less, given that the illness runs its normal course, as evidenced by the following clinical indications:

(Signature of Hospice Medical Director)

(date by physician)

Attestation Statement:

By signing this certification, the physician named above, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.

For office use only. Entered into EMR _____

Verbal certification from:

(Medical Director) By _____ / _____
(Staff Member signature) (Date)

Verbal certification from:

(Attending Physician) By _____ / _____
(Staff Member signature) (Date)



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Please include in the feeding order:

- Formula type (include calories/oz. if applicable)
- Rate (mL/hour)
- Duration; continuous 24hr feeding (or) specific intermittent feeding time (ex: 8hrs @ night 11pm-7am)
- With intermittent feeding times **PLEASE CONSIDER:** NCHH policy for max amount of formula in feeding bag:
 - No more than 4 hours for Breast milk & Powdered Formula
 - No more than 8 hours for Liquid & Canned Formula
 - For night feeds over these times (4 or 8 hours), parents will have to refill bag during the night
 - No longer recommending ice pack in back-pack with formula
 - Bolus feeding; specify frequency & whether by syringe gravity (or) on pump with duration (ex: 100mL bolus over 30min on pump every 3 hours @ 6am-9am-12pm-3pm-6pm)

Supplies are sent monthly (every 30 days):

- Monthly allowable amounts are located beside each item, unless specified otherwise
 - Examples: feeding bags (30) = 30 per month, Stethoscope (1 total) = 1 time only
-

N-G Tube Supply List:

- Replacement NG Tube Size/Type (2)
- Stethoscope (1 total)
- Thin Duoderm patches (4)
- Syringes 6mL & 10 mL (7)
- 1 inch silk Tape (1, then prn)
- Non-sterile gloves (1 box)
- Who is to provide formula

If applicable:

- portable enteral pump (1 total)
- feeding bags (30)
- Back-pack/fanny pack (1 total)

N-J Tube Supply List:

- Thin Duoderm patches (4)
- Syringes 6mL & 10mL (7)
- 1 inch silk Tape (1, then prn)
- Non-sterile gloves (1 box)
- Who is to provide formula

If applicable:

- portable enteral pump (1 total)
- feeding bags (30/month)
- Back-pack/fanny pack (1 total)

G Tube & G-J Tube Supply List:

- Replacement Tube Size/Type 4/yr)
- Split 2x2 gauze (35)
- Non-sterile Q-tips (100)
- Syringes 6mL & 10mL (7)
- 1 inch silk Tape (1, then prn)
- Non-sterile gloves (1 box)
- Who is to provide formula

If applicable:

- portable enteral pump (1 total)
- feeding bags (30)
- Back-pack/fanny pack (1 total)

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Mickey Button Supply List:

- Replacement Tube Size/Type (4/yr)
- Mickey extension tubing sets:
 - “continual feeding tubes” (4)
 - “bolus feeding tubes” (2)
- Split 2x2 gauze (35)
- Non-sterile Q-tips (100)
- Syringes 6mL & 10mL (7)
- 1 inch silk Tape (1, then prn)
- Non-sterile gloves (1 box)
- Who is to provide formula

If applicable:

- portable enteral pump (1 total)
- feeding bags (30/month)
- Back-pack/fanny pack (1 total)

Farrell Bag Supply List:

- Farrell Bags (30)
- IV pole (only with Farrell Bags)

Bolus Feeds Supply List:

- 60mL Syringes (4)
- See list specific to tube type

Feeding Bags:

500mL bags: for rates up to 60mL/hr (ex: 60mL x 8 hrs=480mL)

1200mL bags: for rates above 60mL/hr (ex: 75mL x 8 hrs=600mL)

Syringes:

Available Sizes: 6mL w/oral slip tip and 10mL & 60mL in cath tip

- Per homecare policy, we **CANNOT** supply “Christmas tree” adaptors in the home as a safety precaution due to risk of caregivers removing adaptor & then the syringe would fit onto an IV connection.



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Name: _____

MRN: _____

DOB: _____

Please admit patient to hospice.

Physician Signature

Date



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