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### Pediatric Asthma Orders for Emergent/Urgent Care

Recommended for children aged 12 months – 18 years  
with a diagnosis of asthma

#### Instructions for completing orders:

- Determine PRAM Clinical Score as per the **Alberta Acute Childhood Asthma Pathway for Emergent/Urgent Care** and select orders based on PRAM Score.
- All orders that are pathway compatible (indicated by ) will be followed automatically.
- Optional orders (indicated by ) can be given by selecting the corresponding check boxes.
- Custom orders can be written on **page 4**.
- To cancel pre-selected orders, strike through and initial.
- If subsequent orders are added after initial sign-off, then date/time and initials should be indicated for each additional order given.
- Select and sign **one order set**:
  - PRAM Score 0 – 4 Mild** – go to **page 1**
  - PRAM Score 5 – 8 Moderate** – go to **page 2**
  - PRAM Score 9 – 12 Severe** – go to **pages 3-4**
  - Impending Respiratory Failure** – go to **pages 5-6**

#### PRAM Score 0 – 4 Mild

Follow Mild asthma orders for **Alberta Acute Childhood Asthma Pathway for Emergent/Urgent Care**

<input checked="" type="checkbox"/> Determine weight on admission	Weight: _____ kg
<input checked="" type="checkbox"/> Salbutamol inhaler via MDI/spacer	<ul style="list-style-type: none"> <li>• If less than 20 kg, 5 puffs times _____ doses</li> <li>• If 20 kg or greater, 10 puffs times _____ doses</li> </ul>
<input type="checkbox"/> Salbutamol inhaler via MDI/spacer	<ul style="list-style-type: none"> <li>• If less than 20 kg, 5 puffs q30-60 min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD</li> <li>• If 20 kg or greater, 10 puffs q30-60 min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD</li> </ul>
<input type="checkbox"/> Salbutamol solution via nebulizer	<ul style="list-style-type: none"> <li>• If less than 20 kg, 2.5 mg once</li> <li>• If 20 kg or greater, 5 mg once</li> </ul>
<input type="checkbox"/> Dexamethasone liquid _____ mg PO. <i>(Recommended dose is 0.3 mg/kg/DOSE after first aerosol treatment; round to the nearest whole number. Max dose 10 mg)</i>	
<input type="checkbox"/> PredniSONE/prednisoLONE _____ mg PO. <i>(Recommended dose is 2 mg/kg/DOSE. Max dose 60 mg)</i>	
<input checked="" type="checkbox"/> Provide asthma teaching for patient and family	
<input checked="" type="checkbox"/> Refer to highest level of asthma education available	

Date <i>(yyyy-Mon-dd)</i>	Time <i>(hh:mm)</i>	Name of Physician <i>(print)</i>	Signature

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**Pediatric Asthma Orders for Emergent/Urgent Care**

Recommended for children aged 12 months – 18 years  
with a diagnosis of asthma

**PRAM Score 5 – 8 Moderate**

- Follow Moderate asthma orders for **Alberta Acute Childhood Asthma Pathway for Emergent/Urgent Care**
- All orders that are pathway compatible (indicated by  ) will be followed automatically.
- Optional orders (indicated by  ) can be given by selecting the corresponding check boxes.
- Custom orders can be written on **page 4**.
- To cancel pre-selected orders, strike through and initial.
- If subsequent orders are added after initial sign-off, then date/time and initials should be indicated for each additional order given.

<input checked="" type="checkbox"/> Determine weight on admission	Weight: _____ kg		
<input type="checkbox"/> O <sub>2</sub> Therapy (Titrate to Saturation) – Maintain SpO <sub>2</sub> at 95%			
<input checked="" type="checkbox"/> Salbutamol inhaler via MDI/spacer	<ul style="list-style-type: none"> <li>• If less than 20 kg, 5 puffs q20min, times 3 doses</li> <li>• If 20 kg or greater, 10 puffs q20min, times 3 doses</li> </ul>		
<input checked="" type="checkbox"/> Ipratropium inhaler 4 puffs via MDI/spacer q20min, times 3 doses			
<input type="checkbox"/> Salbutamol inhaler via MDI/spacer	<ul style="list-style-type: none"> <li>• If less than 20 kg, 5 puffs q30-60min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD</li> <li>• If 20 kg or greater, 10 puffs q30-60min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD</li> </ul>		
<input type="checkbox"/> Salbutamol solution via nebulizer via oxygen	<ul style="list-style-type: none"> <li>• If less than 20 kg, 2.5 mg q20min, times 3 doses</li> <li>• If 20 kg or greater, 5 mg q20min, times 3 doses</li> </ul>		
<input type="checkbox"/> Ipratropium solution via nebulizer via oxygen, 250 mcg q20min, times 3 doses			
<input checked="" type="checkbox"/> Dexamethasone liquid PO. <i>(Recommended dose is 0.3 mg/kg/DOSE after first aerosol treatment; round to the nearest whole number. Max dose 10 mg)</i>			
<input type="checkbox"/> PredniSONE/prednisOLONE _____ mg PO. <i>(Recommended dose is 2 mg/kg/DOSE. Max dose 60 mg)</i>			
<input checked="" type="checkbox"/> Provide asthma teaching for patient and family			
<input checked="" type="checkbox"/> Refer to highest level of asthma education available			
<input type="checkbox"/> Notify attending Physician after first three aerosol treatments			
<input type="checkbox"/> Notify attending Physician 4 hours after steroid is administered			
<input type="checkbox"/> Notify attending Physician if PRAM Score increases by greater than or equal to 3 points			
<b>Date</b> <i>(yyyy-Mon-dd)</i>	<b>Time</b> <i>(hh:mm)</i>	<b>Name of Physician</b> <i>(print)</i>	<b>Signature</b>

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### Pediatric Asthma Orders for Emergent/Urgent Care

Recommended for children aged 12 months – 18 years  
with a diagnosis of asthma

#### PRAM Score 9 – 12 Severe (continued on next page)

- Follow Severe asthma orders for **Alberta Acute Childhood Asthma Pathway for Emergent/Urgent Care**
- All orders that are pathway compatible (indicated by ) will be followed automatically.
- Optional orders (indicated by ) can be given by selecting the corresponding check boxes.
- Custom orders can be written on **page 4**.
- To cancel pre-selected orders, strike through and initial.
- If subsequent orders are added after initial sign-off, then date/time and initials should be indicated for each additional order given.

<input checked="" type="checkbox"/> Determine weight on admission	Weight: _____ kg		
<input checked="" type="checkbox"/> NPO			
<input checked="" type="checkbox"/> O <sub>2</sub> Therapy – Maintain SpO <sub>2</sub> at 95% or greater			
<input checked="" type="checkbox"/> Salbutamol Solution (continuous via large volume nebulizer)	• If less than 20 kg, 7.5 mg via oxygen (mix with ipratropium and normal saline to make total volume of 20 ml) (O <sub>2</sub> flowrate at minimum 8 LPM)		
	• If 20 kg or greater, 15 mg via oxygen (mix with ipratropium and normal saline to make total volume of 20 ml) (O <sub>2</sub> flowrate at minimum 8 LPM)		
<input checked="" type="checkbox"/> Ipratropium solution (continuous via large volume nebulizer), 750 mcg via oxygen (mix with salbutamol and normal saline to make total volume of 20 ml) (O <sub>2</sub> flowrate at minimum 8 LPM)			
<input type="checkbox"/> Salbutamol inhaler via MDI/spacer	• If less than 20 kg, 5 puffs q20min, times 3 doses		
	• If 20 kg or greater, 10 puffs q20min, times 3 doses		
<input type="checkbox"/> Ipratropium inhaler 4 puffs via MDI/spacer q20min, times 3 doses			
<input type="checkbox"/> Salbutamol inhaler via MDI/spacer	• If less than 20 kg, 5 puffs q30-60min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD		
	• If 20 kg or greater, 10 puffs q30-60min PRN if PRAM Score greater than 3 at reassessment; if administered q30min notify MD		
<input checked="" type="checkbox"/> Dexamethasone liquid PO. (Recommended dose is 0.3 mg/kg/DOSE after first aerosol treatment; round to the nearest whole number. Max dose 10 mg)			
<input type="checkbox"/> PredniSONE/prednisoLONE _____ mg PO. (Recommended dose is 2 mg/kg/DOSE. Max dose 60 mg)			
<input type="checkbox"/> Dexamethasone injection _____ mg IM once if IV/IO not available. (Recommended dose is 0.3 mg/kg/DOSE; round to the nearest whole number. Max dose 10 mg)			
<input type="checkbox"/> HydroCORTISone Na succinate injection _____ mg IV once. (Recommended dose is 4 – 8 mg/kg/DOSE. Max dose 400 mg)			
<input type="checkbox"/> MethyIPREDNISolone Na succinate injection _____ mg IV once. (Recommended dose is 1– 2 mg/kg/DOSE. Max dose 80 mg)			
<input type="checkbox"/> Insert intravenous cannula			
<input type="checkbox"/> 0.9% sodium CHLORIDE bolus infusion IV via peripheral line, 20 mL/kg as fast as possible			
<input type="checkbox"/> Magnesium SULPHATE injection _____ mg IV infusion over 20 minutes once. (Recommended dose is 40 mg/kg/DOSE IV infusion over 20 minutes. Max dose 2000 mg)			
<input type="checkbox"/> Salbutamol infusion IV (continuous). Start at 1 mcg/kg/min, titrate upwards as per physician verbal order			
<b>Date</b> (yyyy-Mon-dd)	<b>Time</b> (hh:mm)	<b>Name of Physician</b> (print)	<b>Signature</b>

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**Pediatric Asthma Orders for Emergent/Urgent Care**

Recommended for children aged 12 months – 18 years  
with a diagnosis of asthma

**PRAM Score 9 – 12 Severe (continued)**

- Provide asthma teaching for patient and family
- Refer to highest level of asthma education available
- Notify attending Physician after first three aerosol treatments
- Notify attending Physician 4 hours after steroid is administered
- Notify attending Physician if PRAM Score increases by greater than or equal to 3 points

Date (yyyy-Mon-dd)	Time (hh:mm)	Name of Physician (print)	Signature
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**Other orders**

<b>Respiratory Care</b>	<input type="checkbox"/> Continuous oxygen saturation monitoring
	<input type="checkbox"/> O <sub>2</sub> Sats on room air with vitals
	<input type="checkbox"/> O <sub>2</sub> Sats on O <sub>2</sub> therapy with vitals
	<input type="checkbox"/> O <sub>2</sub> Therapy (Non-rebreathing Mask) – Administer O <sub>2</sub> for PRAM Score 5-12 to maintain O <sub>2</sub> Sat at 95% or greater
<b>Clinical Communication</b>	<input type="checkbox"/> Call for old charts
	<input type="checkbox"/> Refer for asthma education
	<input type="checkbox"/> Refer to Asthma Clinic
	<input type="checkbox"/> Refer to Pediatrician
<b>Blood gases</b>	<input type="checkbox"/> Capillary blood gas, once, STAT on current therapy
	<input type="checkbox"/> Venous blood gas, once, STAT on current therapy
	<input type="checkbox"/> Arterial blood gas, once from radial artery, STAT on current therapy
<b>Chest X-rays</b>	<input type="checkbox"/> Chest X-ray, AP and Lateral STAT
	<input type="checkbox"/> Chest X-ray, PA portable STAT

**Custom orders**

Date (yyyy-Mon-dd)	Time (hh:mm)	Name of Physician (print)	Signature
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### Pediatric Asthma Orders for Emergent/Urgent Care

Recommended for children aged 12 months – 18 years with a diagnosis of asthma

#### Impending Respiratory Failure *(continued on next page)*

- Follow Impending Respiratory Failure orders for **Alberta Acute Childhood Asthma Pathway for Emergent/Urgent Care**
- All orders that are pathway compatible (indicated by ) will be followed automatically.
- Optional orders (indicated by ) can be given by selecting the corresponding check boxes.
- Custom orders can be written on **page 6**.
- To cancel pre-selected orders, strike through and initial.
- If subsequent orders are added after initial sign-off, then date/time and initials should be indicated for each additional order given.

<input checked="" type="checkbox"/> Determine weight on admission	Weight: _____ kg		
<input checked="" type="checkbox"/> NPO			
<input checked="" type="checkbox"/> 100% O <sub>2</sub> Therapy (Non-rebreathing Mask)			
<input checked="" type="checkbox"/> Salbutamol solution (continuous via large volume nebulizer)	<ul style="list-style-type: none"> <li>• If less than 20 kg, 7.5 mg via oxygen (mix with ipratropium and normal saline to make total volume of 20 ml) (<i>O<sub>2</sub> Flowrate 8 LPM</i>)</li> <li>• If 20 kg or greater, 15 mg via oxygen (mix with ipratropium and normal saline to make total volume of 20 ml) (<i>O<sub>2</sub> Flowrate 8 LPM</i>)</li> </ul>		
<input checked="" type="checkbox"/> Ipratropium solution (continuous via large volume nebulizer), 750 mcg via oxygen (mix with salbutamol and normal saline to make total volume of 20 ml) ( <i>O<sub>2</sub> Flowrate 8 LPM</i> )			
<input type="checkbox"/> EPINEPHrine injection _____ mL of 1:1000 solution IM. ( <i>Recommended dose is 0.01 mL/kg of 1:1000 solution, max dose 0.5 mL</i> )			
<input checked="" type="checkbox"/> Insert intravenous cannula			
<input type="checkbox"/> Insert second intravenous cannula			
<input type="checkbox"/> HydroCORTISone Na succinate injection _____ mg IV once. ( <i>Recommended dose is 4 - 8 mg/kg/DOSE. Max dose 400 mg</i> )			
<input type="checkbox"/> MethylPREDNISolone Na succinate injection _____ mg IV once. ( <i>Recommended dose is 1 - 2 mg/kg/DOSE. Max dose 80 mg</i> )			
<input type="checkbox"/> Dexamethasone injection _____ mg IM once (if IV/IO not available). ( <i>Recommended dose is 0.3 mg/kg/DOSE; round to the nearest whole number. Max dose 10 mg</i> )			
<input type="checkbox"/> 0.9% sodium CHLORIDE bolus infusion IV via peripheral line, 20 mL/kg as fast as possible			
<input type="checkbox"/> D5W-0.9% sodium CHLORIDE infusion IV via peripheral line, _____ mL/hr (maintenance IV fluid)			
<input type="checkbox"/> Magnesium SULPHATE injection _____ mg IV infusion over 20 minutes once. ( <i>Recommended dose is 40 mg/kg/DOSE IV infusion over 20 minutes. Max dose 2000 mg</i> )			
<b>Date</b> (yyyy-Mon-dd)	<b>Time</b> (hh:mm)	<b>Name of Physician</b> (print)	<b>Signature</b>



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**Pediatric Asthma Orders for Emergent/Urgent Care**

Recommended for children aged 12 months – 18 years with a diagnosis of asthma

**Impending Respiratory Failure** *(continued)*

Salbutamol infusion IV (continuous). Start at 1 mcg/kg/min, titrate upwards as per physician verbal order

Chest X-rays

Chest X-ray, AP and Lateral STAT

Chest X-ray, PA portable STAT

Blood gases

Capillary blood gas, once, STAT on current therapy

Venous blood gas, once, STAT on current therapy

Arterial blood gas, once from radial artery, STAT on current therapy

Rapid Sequence Induction

Atropine \_\_\_\_\_ mg IV once. *(Recommended dose is 0.02 mg/kg. Max dose 1 mg)*

Midazolam \_\_\_\_\_ mg IV once. *(Recommended dose is 0.05 to 0.2 mg/kg)*

Ketamine \_\_\_\_\_ mg IV once. *(Recommended dose is 2 mg/kg)*

Succinylcholine \_\_\_\_\_ mg IV once. *(Recommended dose: if less than 1 year - 3 mg/kg, if 5 years or less - 2 mg/kg, if 5 years or greater - 1.5 mg/kg)*

Rocuronium \_\_\_\_\_ mg IV once. *(Recommended dose is 1 mg/kg)*

**Custom orders**

Sample

**Date** *(yyyy-Mon-dd)*

**Time** *(hh:mm)*

**Name of Physician** *(print)*

**Signature**