<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient Phone #:</th>
<th>Start of Care Date:</th>
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**Date of Birth:**

**HT:**

**WT:**

**Allergies:**

**SOC Bilirubin:**

**Type of Therapy:**

- **Biliblanket**
- **Bilicrib**
- **Doublebank**

**Transdermal BiliChek Lab Order:** Skilled nurse to perform weight check and Bili level measurement per use of BiliChek (Infants with a bilirubin level of 18 or less).

***Patient to have serum bilirubin lab performed if unable to retrieve level via BiliChek if total bilirubin level is greater than 18 or protective skin patch is removed or not intact.

**-OR-**

**Serum Bilirubin Level Lab Order:** Skilled nurse to perform weight check and obtain lab for bilirubin level.

***Patient to have serum bilirubin lab performed if unable to retrieve level via BiliChek if total bilirubin level is greater than 18 or protective skin patch is removed or not intact.

**Additional labs:**

**Call results to:**

**Phone #:**

**Special Instructions:**

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**Clinician Signature**

**Date/Time**

**TORB / VORB**

(Circle)

**Physician Signature**

**Date/Time**

REVISED 04/30/2009

HHPOCHMPHT