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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			
<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  
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**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 (Titrated 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 _____ 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/predniLONE _____ 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> (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 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 _____ mg 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"/> MethylPREDNISolone 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, PA and lateral
	<input type="checkbox"/> Chest X-ray, AP 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 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**