

Discharge Checklist for Infants with Hypoglycemia and Hypopituitarism

CHECK BOXES AND INITIAL WHEN COMPLETED	Initials
<p>Parent or Caregiver Teaching:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Met with the Endocrinology Nurse or physician to discuss diagnosis <input type="checkbox"/> Use of glucometer <input type="checkbox"/> Target range of blood sugars ____ mmol/L to ____ mmol/L <input type="checkbox"/> At home treatment of hypoglycemia (low blood sugar < 3.2 mmol/L) <input type="checkbox"/> Medication teaching (see below) <input type="checkbox"/> To contact Pediatric Endocrinology if the blood sugars are frequently too low (<3.2 mmol/L) or high (>6.0mmol/L) <p>Pediatric Endocrinology nurse: Monday to Friday 8:00am - 4:00 pm at 204-787-2490 Pediatric Endocrinologist physician on call: 24 hour on call at 204-787-2071</p>	
<p>Medication:</p> <p><input type="checkbox"/> Prednisolone (Glucocorticoid)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dose of Prednisolone is ____ mg = ____ ml ____ times a day by mouth <input type="checkbox"/> Caregiver(s) has been instructed how to give this medication by _____ <input type="checkbox"/> Illness management reviewed - dose will be doubled in case of illness or fever <input type="checkbox"/> Illness Management Plan Letter provided <input type="checkbox"/> Teaching and prescriptions for other pituitary replacement hormones if applicable (growth hormone and/or L-thyroxine and/or DDAVP) (circle if applicable) <input type="checkbox"/> Pediatric Endocrinologist has provided prescription to Pharmacy _____ (standard concentration for Prednisolone will be 1mg/ml) <p>OR</p> <p><input type="checkbox"/> Growth hormone</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dose of growth hormone is ____ mg/ day 7 days per week <input type="checkbox"/> Caregiver(s) has been instructed how to give this medication by _____ <input type="checkbox"/> How to prepare _____ <input type="checkbox"/> Pediatric Endocrinology has sent the prescription to NIFB; GH was approved _____ (date) 	
<p><input type="checkbox"/> Glucagon (optional)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caregiver(s) has been instructed how to give intramuscular glucagon in case of emergency by _____ Dose _____ mg IM 	
<p><input type="checkbox"/> IM Hydrocortisone (optional)</p> <p>Caregiver(s) has been instructed how to give intramuscular hydrocortisone in case of emergency by _____ Dose _____ mg IM</p>	
<p>Infant's Clinical Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infant must be able to maintain a blood sugar of at least 3.3 mmol/L pre feeds <input type="checkbox"/> The infant should be fasted in the NICU prior to discharge and be able to maintain this target blood sugar after a minimum of 4 h (ideally 5 or 6 hours) <p>After _____ hours - _____ mmol/L - date _____</p>	
<p>Discharge Preparation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caregiver has all medications checked off above, in hand prior to discharge <input type="checkbox"/> Clinic Follow up Appointment with Pediatric Endocrinology Booked: <p>Date _____ Time _____</p>	<input type="checkbox"/>

- Date and name of person who has completed this form