SICKLE CELL ANEMIA
ACUTE CHEST SYNDROME ORDERS
(Adapted with permission from the IWK Health Centre-June 2017)

Patient: _____

Age ____ Wt: _____ kg Date of Wt (dd/mm/yyyy) _____

Allergies: _____

The following orders will be carried out by a licensed healthcare professional **ONLY ON THE AUTHORITY OF AN APPROVED PRESCRIBER. Where choice occurs, check as appropriate.**

Refer to APPHON Guidelines for the Management of Sickle Cell Disease. For infants less than 1 month - refer to IWK Neonatal Dosing Guidelines.

Required Evaluations	Daily CBC, Diff Daily Na, K, Cl, BUN, Creatinine, ALT, AST, BILITD, venous/cap blood gas, reticulocyte count Blood cultures prior to administration of antibiotics if possible Chest X-ray AP + lateral Maintain O_2 saturation greater than or equal to 93% Physical Exam: include cardiopulmonary status, neurologic exam, spleen size If pain in lower limbs for more than 24 hours do Doppler studies For deteriorating patients: Consult Respirologist, assess need for pulmonary ventilation perfusion (V/Q) scan, bronchoscopy
Optional Evaluations Please check as appropriate	□ Urinalysis □ Urine Culture □ NP (PCR) swab for □ Influenza, □ RSV, □ Adenovirus, □ Other _____ □ Throat swab for mycoplasma □ Other: _____
Vital Signs	Every hour until stable, then q4h and within 30 minutes prior to leaving the hospital
Other	Quiet activities x 24 h and normal diet (avoid very cold drinks and caffeine)
	Complete respiratory function tests on day of discharge

Treatment	
Hydration	IV D5W + 0.9% NaCl at 1 ½ x maintanence = _____ mL/hour (up to 150 mL/hour) or oral equivalent
Respiratory	Salbutamol _____ mg via nebulization q4h prn. (0.1 – 0.15 mg/kg/dose) Incentive spirometer 10 breaths q2h while awake
Blood	If blood transfusion required refer to Routine Transfusion Orders Form IWKPERO and Clinical Policy # 625 Administration of Blood Products
Fever	If fever refer to Sickle Cell Fever orders(Form ID IWKSICEAN)
Pain	If no contraindication: Ibuprofen _____ mg PO q6h (6 months and older 10 mg/kg/dose, maximum 40 mg/kg/24hours or 2.4 grams/24 hours) If uncontrolled pain refer to Sickle Cell Anemia Pain Orders (Form ID IWKSICEANPA)

DATE (dd/mm/yyyy)	Time (24hr/hh:mm)	Prescriber Signature	Printed Surname/Registration#
DATE (dd/mm/yyyy)	Time (24hr/hh:mm)	Verified By (Signature)	Printed Surname