



**Nicklaus
Children's
Hospital**

FIN: _____

MR#: _____

Time Bed Requested: _____

Room Assigned: _____ Time: _____

Room Ready: **yes** Time Room Ready: _____

Isolation: Single Semi-Private

DIRECT ADMISSION

ADMITTING OFFICE USE ONLY

ORDER TYPE: VERBAL TELEPHONE EMAIL FAXED (305) 669-7149

ADMIT RN: _____

- Elective
- Urgent
- Inpatient Observation

DATE OF ADMISSION: _____

UNIT REQUESTED: _____

Source:

M.D Office. _____ Pediatric Care Clinic _____

Outpatient Clinic _____ Other _____

Patient Name: _____ Age: _____ Date of Birth: _____

Diagnosis: _____ ICD Code: _____ Sex: M / F

Co-morbidities: _____

Please list any indwelling lines, tubes, or drains: _____

Reason for Admission: _____

Admitting Physician: _____ Telephone (Cell): _____

Referring MD: _____ After-hours contact # (Cell): _____

PC Phy : _____ Telephone: _____

Parent Name: _____ Parent Phone # : _____

Insurance: _____ Authorization: _____

INTERNATIONAL Yes No

Scheduled Date: _____ Time: _____ AM / PM Physician Signature: _____

Nicklaus Children's Hospital Admitting Office Fax Number: (305) 663-8466

Please call Admitting Nurse (305) 662-8259 to confirm receipt of request.

If it is your preference to email instead of fax, please email:

admittingnurses@nicklaushealth.org