



**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](mailto:admittingnurses@nicklaushealth.org)**