OREGON CENTER FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS

Oregon Health Emergency Protocol

How-to Guide

Purpose:

The Oregon Health Emergency Protocol form is available for any patient whose medical or mental health condition(s) require specific non-standard treatment, or when there is a known best course of treatment, should they suffer a medical emergency related to that condition. The form may only be completed and signed by an authorized health care provider with a verifiable license.

Completing this form allows health care providers to communicate their care recommendations directly to emergency department staff. Providers may encounter this form in multiple ways: patient/caregiver provides a copy of the form to the emergency department, in the electronic medical record, and for patients ages 0-26 it may be found in the HERO Kids Registry.

The form is for emergency medical use only. It does not guarantee specific care, treatment, action, or hospital. Having this information supports more informed care.

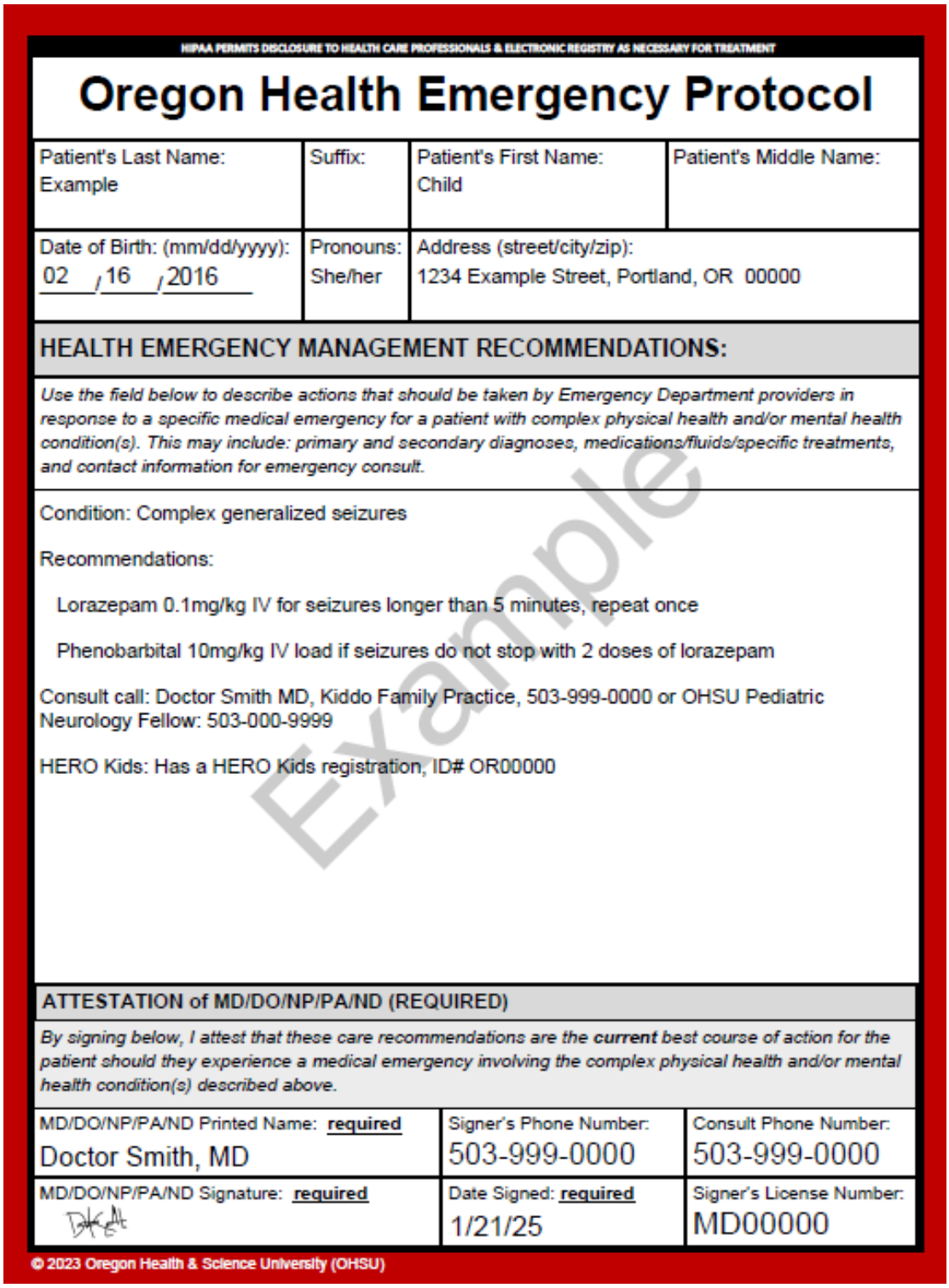
Field Guide:

If a field does not apply to the patient, you may leave it blank. Required fields will be noted with a red asterisk (*).	
FIELD	NOTES
Patient's Last Name*	*Last Name*
Suffix	*Examples: Sr., Jr., III*
Patient's First Name*	*First Name*
Date of Birth*	*MM/DD/YYYY format*
Pronouns	*Examples: he/him, she/her, they/them, ze/hir*
Health Emergency Management Recommendations*	*Describe actions that should be taken by emergency department providers in response to a specific medical emergency for a patient with complex physical health and/or mental health condition(s). This may include primary and secondary diagnoses, medications/fluids/specific treatments, and contact information for emergency consult.*
MD/DO/NP/PA/ND Printed Name*	*Provider's printed name.*
Signer's Phone Number	*Provider's office phone or direct line.*
Consult Phone Number	*Best number to call if a consult is needed.*

MD/DO/NP/PA/ND Signature Name*	*Provider's hand-written or verified and approved electronic signature.*
Date Signed*	*Date the form was signed.*
Signer's License Number	*Medical license number. Assists with verification.*

Examples:

Pediatric patient



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon Health Emergency Protocol

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:
Example		Child	
Date of Birth: (mm/dd/yyyy): 02 / 16 / 2016	Pronouns: She/her	Address (street/city/zip): 1234 Example Street, Portland, OR 00000	

HEALTH EMERGENCY MANAGEMENT RECOMMENDATIONS:

Use the field below to describe actions that should be taken by Emergency Department providers in response to a specific medical emergency for a patient with complex physical health and/or mental health condition(s). This may include: primary and secondary diagnoses, medications/fluids/specific treatments, and contact information for emergency consult.

Condition: Complex generalized seizures

Recommendations:

Lorazepam 0.1mg/kg IV for seizures longer than 5 minutes, repeat once

Phenobarbital 10mg/kg IV load if seizures do not stop with 2 doses of lorazepam

Consult call: Doctor Smith MD, Kiddo Family Practice, 503-999-0000 or OHSU Pediatric Neurology Fellow: 503-000-9999

HERO Kids: Has a HERO Kids registration, ID# OR00000

Example

ATTESTATION of MD/DO/NP/PA/ND (REQUIRED)

*By signing below, I attest that these care recommendations are the **current** best course of action for the patient should they experience a medical emergency involving the complex physical health and/or mental health condition(s) described above.*

MD/DO/NP/PA/ND Printed Name: **required**	Signer's Phone Number:	Consult Phone Number:
Doctor Smith, MD	503-999-0000	503-999-0000
MD/DO/NP/PA/ND Signature: **required**	Date Signed: **required**	Signer's License Number:
	1/21/25	MD00000

Adult patient

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Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:
Example		Adult	
Date of Birth: (mm/dd/yyyy): 02 /02 /2002	Pronouns: he/him	Address (street/city/zip): 00000 Street, City, Zip	

HEALTH EMERGENCY MANAGEMENT RECOMMENDATIONS:

Use the field below to describe actions that should be taken by Emergency Department providers in response to a specific medical emergency for a patient with complex physical health and/or mental health condition(s). This may include: primary and secondary diagnoses, medications/fluids/specific treatments, and contact information for emergency consult.

Kevin has congenital muscular dystrophy, as a result he is wheelchair dependent. He has no cognitive or intellectual impairments at baseline.

Access: Kevin has a subcutaneous port in his right upper chest. It does not draw well, but has been successfully used for fluid and medication administration once accessed.

Sepsis Risk: Kevin has had several episodes of sepsis in the last several years, all with gram negative organisms. We believe these are due to decreased intestinal mobility/gastroperesis and/or the presence of the above noted port.

Hypoglycemia: Kevin has experienced significant hypoglycemic episodes, especially if otherwise ill. He responds very well to IV glucose, as his oral intake can be limited by his GI intestinal motility issues.

POLST: Kevin has a POLST on file with Oregon POLST Registry.

ATTESTATION of MD/DO/NP/PA/ND (REQUIRED)

*By signing below, I attest that these care recommendations are the **current** best course of action for the patient should they experience a medical emergency involving the complex physical health and/or mental health condition(s) described above.*

MD/DO/NP/PA/ND Printed Name: **required**	Signer's Phone Number:	Consult Phone Number:
Doctor Smith, MD	503-999-0000	503-999-0000
MD/DO/NP/PA/ND Signature: **required**	Date Signed: **required**	Signer's License Number:
	1/21/25	MD00000