Neonatal Hyperbilirubinemia Pathway

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice.

Glossary of Terms

TSB – total serum bilirubin

- Ordered as "Bilirubin, Total, Newborn" in Fox Valley (FV) Epic
- Ordered as "Bilirubin Total" in MKE/CMG Epic

Direct bilirubin

- Ordered as "Bilirubin, Direct" in Fox Valley (FV) Epic
- Ordered as "Bilirubin Conjugated and Unconjugated" in MKE/CMG Epic

Order sets or Smart sets

- **Inpatient: Gen Peds Neonatal Hyperbilirubinemia Admission**
- **Outpatient: Jaundice Hyperbilirubinemia Smartset**

TRANSFER/DISCHARGE FROM NEWBORN NURSERY

NEONATAL HYPERBILIRUBINEMIA PATHWAY

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice

Exclusion criteria:
- Conjugated hyperbilirubinemia (direct) bilirubin ≥ 1 mg/dL
- Suspected sepsis or ill appearing
- < 35 weeks gestation
- > 2 weeks of age

Neurotoxicity Risk Factors
- Gestational age < 38 wk
- Albumin < 3 g/dL
- Isoimmune hemolytic disease (positive DAT), G6PD deficiency or other known hemolytic condition
- Sepsis
- Significant clinical instability in previous 24 h

FH Birth Center Newborn Nursery is staffed by MCW-CSG pediatricians in addition to private pediatrician groups and FH Family Medicine providers. Therefore, standardization of hyperbilirubinemia management according to CMG protocols is not applicable and will vary based on provider group.
However, there are three meaningful dispositions that interface with the Children's enterprise:

If infant is within 2 mg/dl of the exchange transfusion threshold at any point during the birth hospitalization

→ **Escalation of Care: Consult CW NICU** (see Annotation G)
- Continue phototherapy
- Obtain TSB every 2 hours
- Send STAT labs: CBC, albumin, TSB & direct bilirubin, type and cross match
- Place PIV and start IV fluids (see Annotation H)
- Consider IVIG based on discussion with NICU
- NICU contacts: Call Fellow 1st: 414-404-1940

Infant required phototherapy in the birth hospitalization. Infant and family plan to see PCP

→ **Create safe follow-up plan with PCP, including rebound TSB check and provide verbal sign-out.**
- If after-hours or weekend, then rebound TSB will be ordered by NBN team to be completed at CW lab and followed by PCP.
- Order TSB

No phototherapy required during birth hospitalization

→ **Follow-up with PCP in the recommended interval below based on how far bilirubin level is below threshold**

Phototherapy Threshold (See Figure 1 - Slides 9 and 10) minus TSB	Follow-Up Recommendations
2.0 – 3.4 mg/dl	TSB or TcB in 4 to 24 hours
3.5 – 5.4 mg/dl	TSB or TcB in 1 to 2 days
5.5 – 6.9 mg/dl	If discharging <72 HOL, then follow up within 2 days with TSB or TcB according to clinical judgement. If discharging ≥72 hours, clinical judgement.
≥ 7.0 mg/dl	If discharging <72 HOL, follow up within 3 days with TSB or TcB according to clinical judgement. If discharging ≥72 HOL, use clinical judgement.

CHILDREN'S MEDICAL GROUP (CMG)

NEONATAL HYPERBILIRUBINEMIA PATHWAY

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice

Exclusion criteria:
- Conjugated hyperbilirubinemia (direct) bilirubin ≥ 1 mg/dL
- Suspected sepsis or ill appearing
- < 35 weeks gestation
- > 2 weeks of age

Neurotoxicity Risk Factors
- Gestational age < 38 wk
- Albumin < 3 g/dL
- Isoimmune hemolytic disease (positive DAT), G6PD deficiency or other known hemolytic condition
- Sepsis
- Significant clinical instability in previous 24 h

Consider Epic "Jaundice Hyperbilirubinemia SmartSet" for orders

First Newborn Visit

Does baby meet any of the below criteria?
- Received phototherapy in newborn nursery
- Jaundice within the first 24 hours of life
- Two bilirubin checks with a rate of rise >0.2mg/dL/hr
- Discharge TSB within 5.4mg/dL of phototherapy threshold

Does baby appear significantly jaundiced on exam?

No → **Discontinue hyperbilirubinemia monitoring**
- **Stop checking** TSB when unlikely to exceed phototherapy threshold based on rate of rise <0.2mg/dL/hr
- **Routine Infant Care**

Yes → **Check TSB**
Lab locations and hours
See Addendum A for Weekend and holiday lab process

Does patient require phototherapy?
Confirm through *Epic bilirubin navigator* or BiliTool.org™

No → **Is rate of rise > 0.2mg/dL/hr or does infant have poor feeding/excessive weight loss?**

No → Discontinue hyperbilirubinemia monitoring

Yes → **Re-check TSB in 24 hours**

Yes → **Does patient meet home phototherapy requirements?** (See Annotation C)

Yes → **Start home phototherapy per clinic process – order to be placed by provider.**
Contact case management for biliblanket assistance if needed (414-266-3680)

No → **Proceed with Mission Control Process (414-266-2470) for next steps/direct admit**
(See Annotation L for admission criteria)

Check TSB daily while on home phototherapy
(See Annotation K and Annotation L)

Is TSB falling?

No → **Proceed with Mission Control Process (414-266-2470) for next steps/direct admit**
(See Annotation L)

Yes → **Discontinue home phototherapy when** TSB level is ≥ 2 mg/dL below the treatment threshold at which phototherapy was started, with consideration of risk factors
(See Annotation I)

Are any of the following present at 2 week and 1-month visits:
1. Is the patient still jaundiced at:
   - 2 weeks for formula fed infants?
   - 3-4 weeks for breastfed infants?
   (See Annotation M)
2. Stools pale, gray, or white by inspection or report?
3. Prior direct bilirubin level available and above reference range?

Yes to any → **Evaluate for cholestasis:**
- Obtain TSB & direct bilirubin
- Transition out of pathway for further management

Original: 03.2025
Process Owner: Dr. Angela Baker-Franckowiak

For questions concerning this work: Contact CWGuidelines&Pathways@Childrenswi.org

URGENT CARE

NEONATAL HYPERBILIRUBINEMIA PATHWAY

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice

Exclusion criteria:

- Conjugated hyperbilirubinemia (direct) bilirubin ≥ 1 mg/dL
- Suspected sepsis or ill appearing
- < 35 weeks gestation
- > 2 weeks of age

Neurotoxicity Risk Factors

- Gestational age < 38 wk
- Albumin < 3 g/dL
- Isoimmune hemolytic disease (positive DAT), G6PD deficiency or other known hemolytic condition
- Sepsis
- Significant clinical instability in previous 24 h

Are any of the following present?

- Ill-appearing
- Neurological dysfunction (signs of acute bilirubin encephalopathy such as lethargy, abnormal tone, opisthotonos)

Yes → **Transfer to Emergency Room**

No → **Patient meets pathway inclusion criteria**

Send to appropriate lab for STAT TSB
Lab locations and hours
Use Urgent Care lab process for after-hours lab draws

Does patient require phototherapy?
Confirm through *Epic bilirubin navigator* or BiliTool.org™

Yes → **Proceed with direct admission process**
Hospital Mission Control (414-266-2470)
(See Annotation L)

No → **Discharge Criteria**

- TSB below phototherapy threshold
- Feeding adequately
- **Close follow-up with PCP 1-2 days**
- If rate of rise is >0.2mg/dL/hr, arrange for recheck TSB in 24 hours (either weekend lab or in PMD office)

EMERGENCY DEPARTMENT TRAUMA CENTER (EDTC)

NEONATAL HYPERBILIRUBINEMIA PATHWAY

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice

Exclusion criteria:

- Conjugated hyperbilirubinemia (direct) bilirubin ≥ 1 mg/dL
- Suspected sepsis or ill appearing
- < 35 weeks gestation
- > 2 weeks of age

Neurotoxicity Risk Factors

- Gestational age < 38 wk
- Albumin < 3 g/dL
- Isoimmune hemolytic disease (positive DAT), G6PD deficiency or other known hemolytic condition
- Sepsis
- Significant clinical instability in previous 24 h

Patient meets inclusion criteria

Yes

- Assign triage ESI Level 2
- Nursing notifies provider to order TSB STAT
- Start biliblanket while awaiting results

Does patient require phototherapy?
Confirm through *Epic bilirubin navigator* or BiliTool.org™

No

Discharge Criteria

- TSB below phototherapy threshold
- Feeding adequately
- Close follow-up with PCP 1-2 days
- If rate of rise is >0.2 mg/dL/hr, arrange for recheck TSB in 24 hrs through PCP (if weekend/holiday and PCP cannot arrange outpatient lab, recommend return to EDTC)

Yes

Is TSB within 2mg/dL of exchange transfusion threshold?

Yes

Consult NICU

- Admit to acute care vs NICU based on NICU consult recommendations
- Place PIV and start Maintenance IVF (See Annotation H)
- Send STAT labs: CBC, albumin, direct bilirubin, type & cross match
- Continue biliblanket
- NICU RNs bring down overhead lights to start intensive phototherapy if being admitted to NICU

No

Admit to Acute Care

- Continue biliblanket
- PIV not routinely recommended. Discuss with admitting provider if hydration concerns

For questions concerning this work: Contact CWGuidelines&Pathways@Childrenswi.org

ACUTE CARE
(Fox Valley & Milwaukee)
NEONATAL HYPERBILIRUBINEMIA PATHWAY

This pathway is intended for patients ≥ 35 weeks gestation, ≤ 2 weeks of age with unconjugated (indirect) hyperbilirubinemia or parental concern for jaundice

Exclusion criteria:
- Conjugated hyperbilirubinemia (direct) bilirubin ≥ 1 mg/dL
- Suspected sepsis or ill appearing
- < 35 weeks gestation
- > 2 weeks of age

Neurotoxicity Risk Factors
- Gestational age < 38 wk
- Albumin < 3 g/dL
- Isoimmune hemolytic disease (positive DAT), G6PD deficiency or other known hemolytic condition
- Sepsis
- Significant clinical instability in previous 24 h

Pre-Hospital Evaluation:
- History and physical to determine neurotoxicity risk factors (see Annotation A) and assess for signs of infection or encephalopathy (see Annotation B)
- Obtain TSB

Does patient reach phototherapy threshold?
- No → **Outpatient management per PCP**
- Yes →

Is TSB within 2mg/dL of exchange transfusion threshold?
- Yes → **Consult Neonatology**
  - **NICU required?**
    - Yes → **Admit to NICU**
    - No → **Admit to Acute Care** (see Annotation N)
- No →

Admit to Acute Care
- **Start Intensive Phototherapy:** Expose as much skin surface area as possible.
- **Use "Gen Peds Neonatal Hyperbilirubinemia Admission" order set**
- **Admission labs**
- Obtain TSB on arrival if initial labs were >5 hours prior to admission
- If maternal blood type is Rh negative or unknown, obtain infant blood type and DAT/Coombs (if not previously done)
- If TSB is rising rapidly (>0.2 mg/dL/hour) OR jaundice is unexplained by history and exam OR infant had jaundice in the first 24 hours of life, evaluate for hemolysis (see Annotation D)
  - Obtain CBC no diff, as well as blood type and DAT/Coombs if not previously done
- Consider G6PD level if unexplained hemolysis, rising TSB on phototherapy, or indicated by family history or ethnicity (see Annotation E)
- **Breast milk or formula feed a minimum of every 3 hours, monitor voids and stools** (see Annotation F)
- Lactation consult if desired by caregiver
- If milk supply allows, expressed breast milk is preferred over formula for breastfed infants requiring supplementation

Is TSB within 2mg/dL of exchange transfusion threshold?
- Yes →

Escalation Of Care – Consult Neonatology (see Annotation G)
- Continue phototherapy
- Obtain TSB every 2 hours
- Send STAT labs: CBC, albumin, Direct bilirubin, type & cross match
- Place PIV and start IV fluids (See Annotation H)
- Consider IVIG based on discussion with NICU
- **Consider transfer to NICU**

- No →

Continue Intensive Phototherapy
- Obtain repeat TSB within 12 hours or with next AM lab draw (whichever comes first) until meeting discharge criteria
- Consider repeat TSB sooner if concern for hemolysis *or* if expected to meet discharge criteria (see below)

Discharge Criteria
- TSB level is ≥ 2 mg/dL below the treatment threshold at which phototherapy was started, with consideration of risk factors (see Annotation I)
- Tolerating PO, feeding issues resolved
- Follow-up with PCP within 24-48 hours of discharge
  - Outpatient TSB level in 24 hours for infants ≤4 days of age at discharge, with known hemolysis, gestational age <38 weeks, or history of phototherapy during the birth hospitalization (see Annotation J)

Original: 03.2025
Process Owner: Dr. Angela Baker-Franckowiak

For questions concerning this work: Contact CWGuidelines&Pathways@Childrenswi.org

ANNOTATIONS

ANNOTATION A : Risk factors for developing significant hyperbilirubinemia that should be identified in the newborn nursery and prompt closer observation and follow-up include:

- Lower gestational age (risk increases with each additional week < 40 weeks)
- Jaundice in the first 24h after birth
- Predischarge transcutaneous bilirubin (TcB) or total serum bilirubin (TSB) close to phototherapy threshold
- Hemolysis from any cause, known or suspected, based on rate of rise > 0.2 mg/dL/hr after first 24h of life
- Phototherapy before discharge from nursery
- Parent or sibling requiring phototherapy or exchange transfusion
- Family history or genetic ancestry suggestive of inherited red blood cell disorders, including glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Exclusive breastfeeding with suboptimal intake
- Scalp hematoma or significant bruising
- Down syndrome
- Macrosomic infant of a diabetic mother

Risk factors for developing neurotoxicity (Acute bilirubin encephalopathy) that lower the threshold for initiating treatment include:

- Gestational age < 38 weeks (and increasing with degree of prematurity)
- Albumin < 3.0 g/dL
- Isoimmune hemolytic disease (+DAT), G6PD deficiency, etc.
- Sepsis
- Significant clinical instability in the previous 24 hours

Note: many of the conditions above are considered risk factors because they have negative effects on albumin binding of bilirubin, the blood-brain barrier, or the susceptibility of the brain cells to damage by bilirubin.

ANNOTATION B: The early to intermediate phases of acute bilirubin encephalopathy are characterized by lethargy, hypotonia alternating with hypertonia, arching, retrocollis, opisthotonos, fever, and high-pitched crying. The late phase of acute bilirubin encephalopathy is characterized by the above symptoms, as well as deep stupor and seizures, and is more likely to result in irreversible CNS damage. "Kernicterus" is a term for the chronic central nervous system damage from elevated bilirubin levels, with symptoms that include cerebral palsy, deafness or diminished hearing, dental enamel dysplasia, paralysis of upward gaze, and developmental delay. A patient displaying any signs or symptoms of acute bilirubin encephalopathy is best placed in the neonatal intensive care unit.

ANNOTATION C: For newborn infants who have already been discharged and then develop a TSB above the phototherapy threshold treatment with a home LED-based phototherapy device rather than admission to the hospital is an option for infants who meet the following criteria:

- Gestational age ≥38 weeks
- ≥ 48 hours old
- Clinically well with adequate feeding
- No known hyperbilirubinemia neurotoxicity risk factors
- No previous phototherapy
- TSB concentration no more than 1 mg/dL above the phototherapy treatment threshold
- An LED-based phototherapy device will be available in the home without delay
- TSB can be measured daily
- Follow up plan set with family (provider is confident family will be able to follow up as needed)

*Note: The effectiveness of home phototherapy varies with the quality of the device and the ability of the family to appropriately use it. This option should be used with caution and close follow up.

ANNOTATION D: Bilirubin is a product of red blood cell breakdown. Therefore, hemolysis will cause the TSB to rise faster than physiologic jaundice or breastfeeding (suboptimal intake) jaundice. Hemolysis is a risk factor for acute bilirubin encephalopathy and kernicterus. Hemolysis should be considered and evaluated for any time the TSB is rising at a rate greater than 0.2 mg/dL/hr or if the TSB does not fall or continues to rise despite intensive phototherapy. In cases in which a bili-blanket has been used at home prior to admission, the rate of rise may be falsely low and special consideration should be given to these patients when deciding whether to evaluate for hemolysis. Infants with known hemolytic disease should have their TSB levels monitored more closely than is recommended by this CPG.

ANNOTATION E: Measurement of the glucose-6-phosphate dehydrogenase (G6PD) level is recommended for infants receiving phototherapy whose family history or ethnic/geographic origin suggests the likelihood of G6PD deficiency, as well as infants whose TSB increases despite phototherapy, increases suddenly, or increases after an initial decline. G6PD should also be considered for formula fed infants readmitted for phototherapy, late onset hyperbilirubinemia, and infants who require escalation of care. G6PD deficiency is more common in Mediterranean, Middle Eastern, Southeast Asian, and African populations. G6PD deficiency occurs in about 13% of African American males and 4% of African American females. Clinicians should note that measuring the G6PD activity during or soon after what appears to be an acute hemolytic event or after an exchange transfusion can lead to a falsely normal result. If G6PD deficiency is strongly suspected, the G6PD activity should be measured at least 3 months later.[1]

ANNOTATIONS (continued)

ANNOTATION F: Unsupplemented breastfed infants experience their maximum weight loss by day 3 of life and up to 10% loss of birth weight by this time is considered normal. Infants with more than 10% loss of birthweight should be evaluated for adequate intake. Evidence of adequate intake in breastfed infants includes 4 to 6 thoroughly wet diapers in 24 hours and 3 to 4 stools per day by the fourth day. By day 3 to 4 of life, stools should have transitioned from meconium to a mustard yellow, mushy or "seedy" stool.[1] Note: At CW, Current practice is to take the baby out of the incubator/bili lights and hold the baby for feeding with bili blanket in place. For all infants, feedings are not longer than 30 minutes. If a provider is concerned about a bili level, the provider may enter an order to feed the baby in the incubator until the bilirubin level comes down.

ANNOTATION G: Neonatology should be consulted for any infants that are at risk for requiring an exchange transfusion. If the TSB is rising rapidly (> 0.2 mg/dL/hr) or is within 2 mg/dL of exchange transfusion threshold, continue intensive phototherapy and initiate escalation of care while consulting the neonatologist. If the infant is requiring escalation of care, consider notifying the blood bank that an exchange transfusion may be necessary.

ANNOTATION H: Intravenous (IV) fluids are not routinely required in infants receiving phototherapy.[1] Oral supplementation is only recommended for infants who are clinically dehydrated, and supplementation with formula or expressed breast milk is often sufficient for hydration in a breastfed infant. A 2017 Cochrane review of healthy, term infants requiring phototherapy for unconjugated hyperbilirubinemia concluded that there is no evidence that IV fluid supplementation affects important clinical outcomes such as bilirubin encephalopathy, kernicterus or cerebral palsy.[5] It is recommended to start IV fluids for infants requiring escalation of care.[1]

ANNOTATION I: The 2022 AAP hyperbilirubinemia clinical practice guideline recommends stopping phototherapy once total serum bilirubin is ≥ 2 mg/dL below the phototherapy threshold at which phototherapy was initiated.[1] Additionally, Barak et al conducted a small randomized controlled trial of 52 infants to better understand what cutoff to use for stopping phototherapy during the birth hospitalization.[6] They compared a TSB 1 mg/dL below the treatment threshold to a TSB 3 mg/dL below the treatment threshold and found that there was no difference in readmissions or need for repeat phototherapy. This study could not determine whether infants with risk factors, such as increased hemolysis by G6PD deficiency, should be treated for longer periods of time.[6] The 2022 AAP guideline recommends shared decision making with families when considering continuing phototherapy beyond the recommended discharge criteria of ≥ 2 mg/dL below the phototherapy threshold at which phototherapy was initiated.[1] In some circumstances, for infants who have met all discharge criteria, it may be appropriate to discharge overnight if desired by the family and approved by the attending physician.

ANNOTATION J: Significant rebound after stopping phototherapy is rare in infants who are readmitted after their birth hospitalization for hyperbilirubinemia, particularly after day 4 of life. Therefore, most infants do not require a rebound bilirubin level. [1,7,8] However, if an infant is less than 4 days old at time of discharge or has hemolytic disease, the risk of rebound is higher, and a follow-up bilirubin level is recommended within 24 hours of stopping phototherapy.[1] If the patient has met discharge criteria, discharge need not be delayed to check a rebound bilirubin level after stopping phototherapy, as long as follow-up with the primary care provider has been arranged.[1] Of note, Children's Wisconsin outpatient laboratory on the main campus has weekend hours by appointment. Discuss this option with case management when arranging weekend discharges for infants who need a level 24 hours after stopping phototherapy.

ANNOTATION K: Discontinuing phototherapy is an option when the TSB has decreased by at least 2 mg/dL below the hour-specific threshold at the initiation of phototherapy. A longer period of phototherapy is an option if there are risk factors for rebound hyperbilirubinemia (eg, gestational age <38 weeks, age <48 hours at the start of phototherapy, hemolytic disease).

ANNOTATION L:

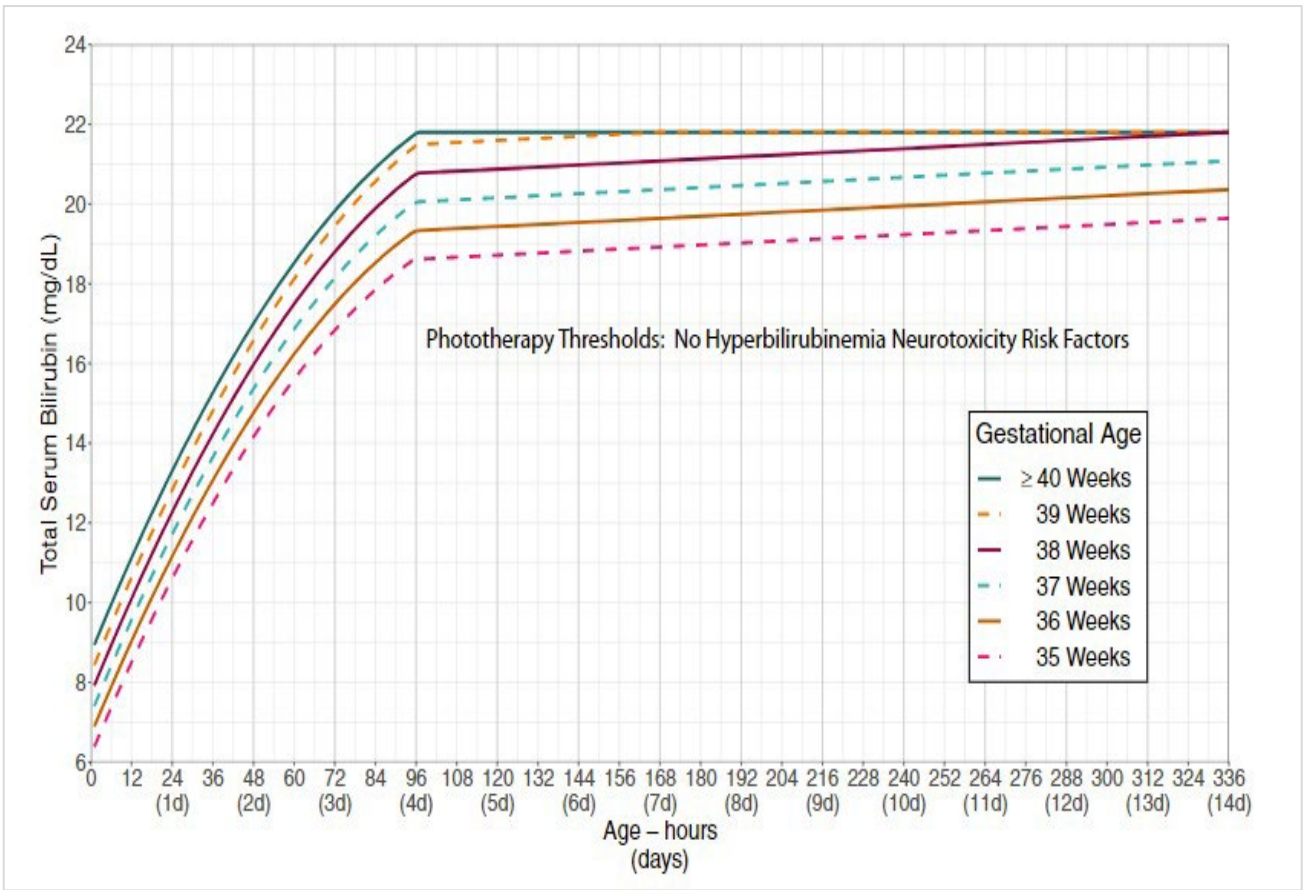
- **Infants currently or previously on home phototherapy** should be admitted for inpatient phototherapy if the TSB increases and the difference between the TSB and the phototherapy threshold narrows (or the TSB is >1 mg/dL above the phototherapy threshold).
- **Infants that have not been on home phototherapy or are not eligible for home phototherapy (see Annotation C)** should be admitted if their TSB meets or exceeds phototherapy threshold. Admission of a patient below phototherapy threshold may be considered based on clinical discretion after considering individual circumstances of a patient.

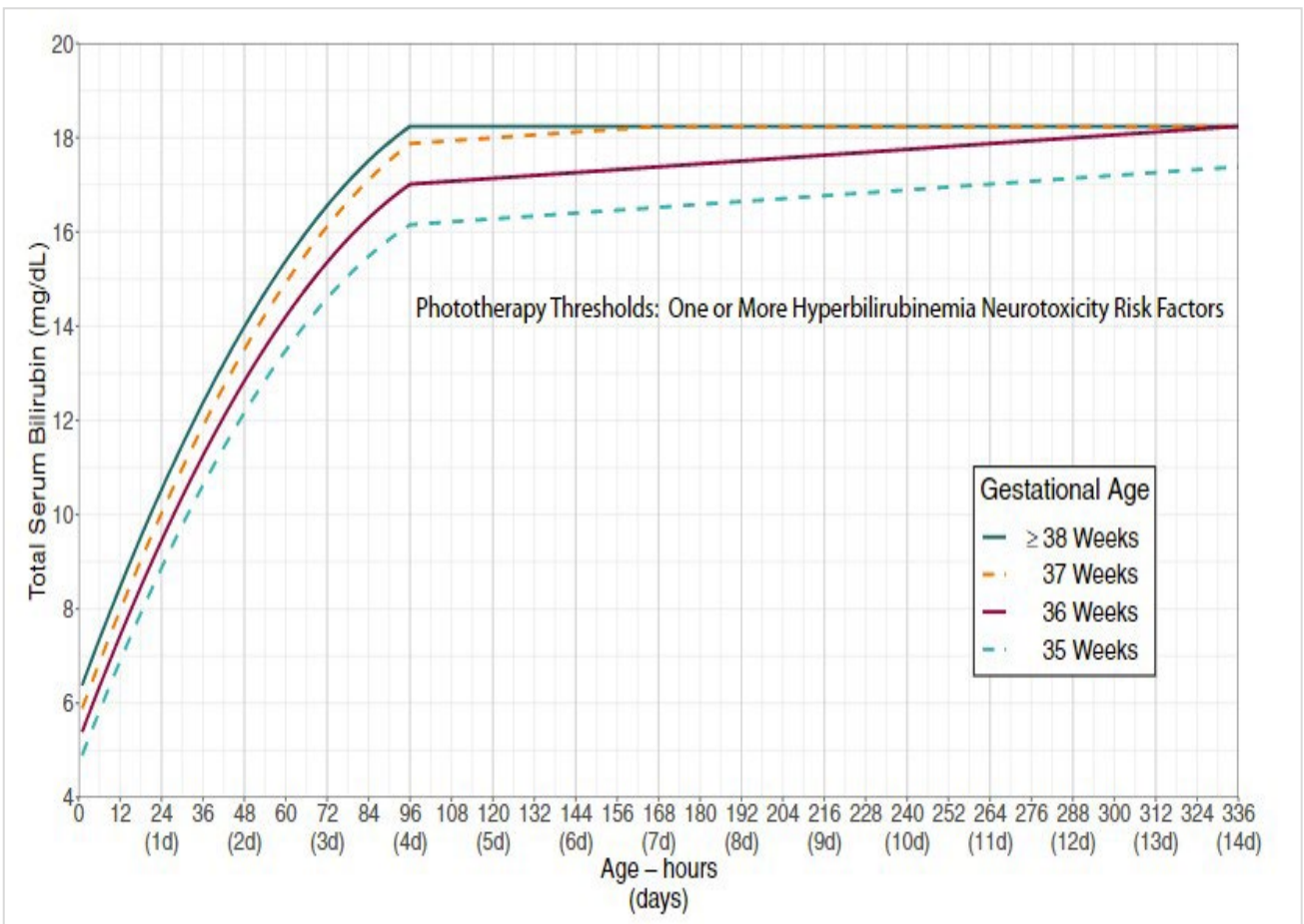
ANNOTATION M: For breastfed infants who are still jaundiced at 3 to 4 weeks of age, and for formula-fed infants who are still jaundiced at 2 weeks of age, the total and direct-reacting (or conjugated) bilirubin concentrations should be measured to identify possible pathologic cholestasis.

ANNOTATION N: In the scenario where TSB is within 2 mg/dL of exchange transfusion threshold prior to phototherapy, NICU consult is recommended. Additional laboratory workup and timing of repeat TSB will be dependent on clinical scenario. Considerations include: gestational age, neurotoxicity risk factors, and TSB value.

Phototherapy Threshold Diagram

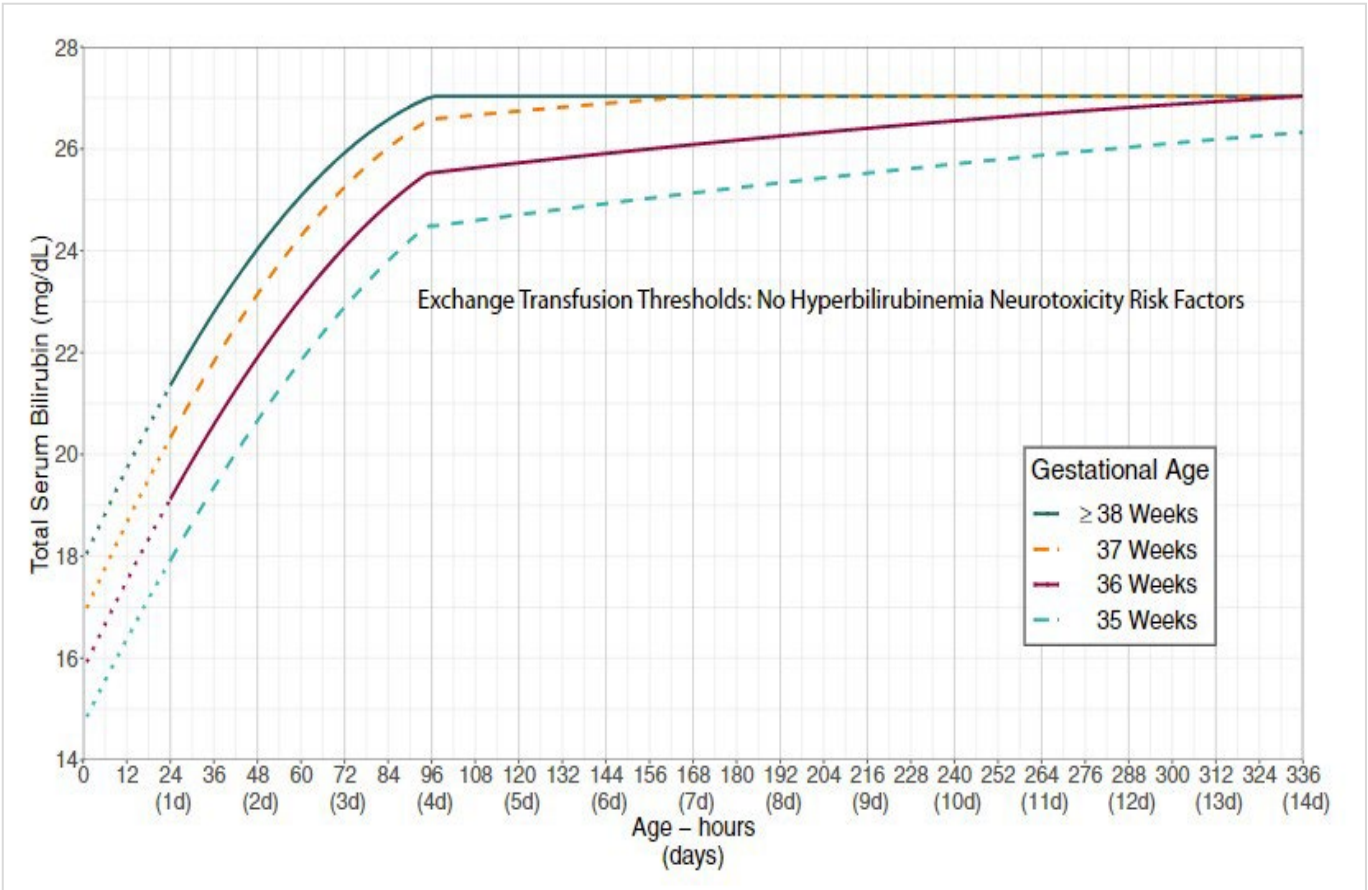
Use EPIC Embedded Bilitool for patient specific results

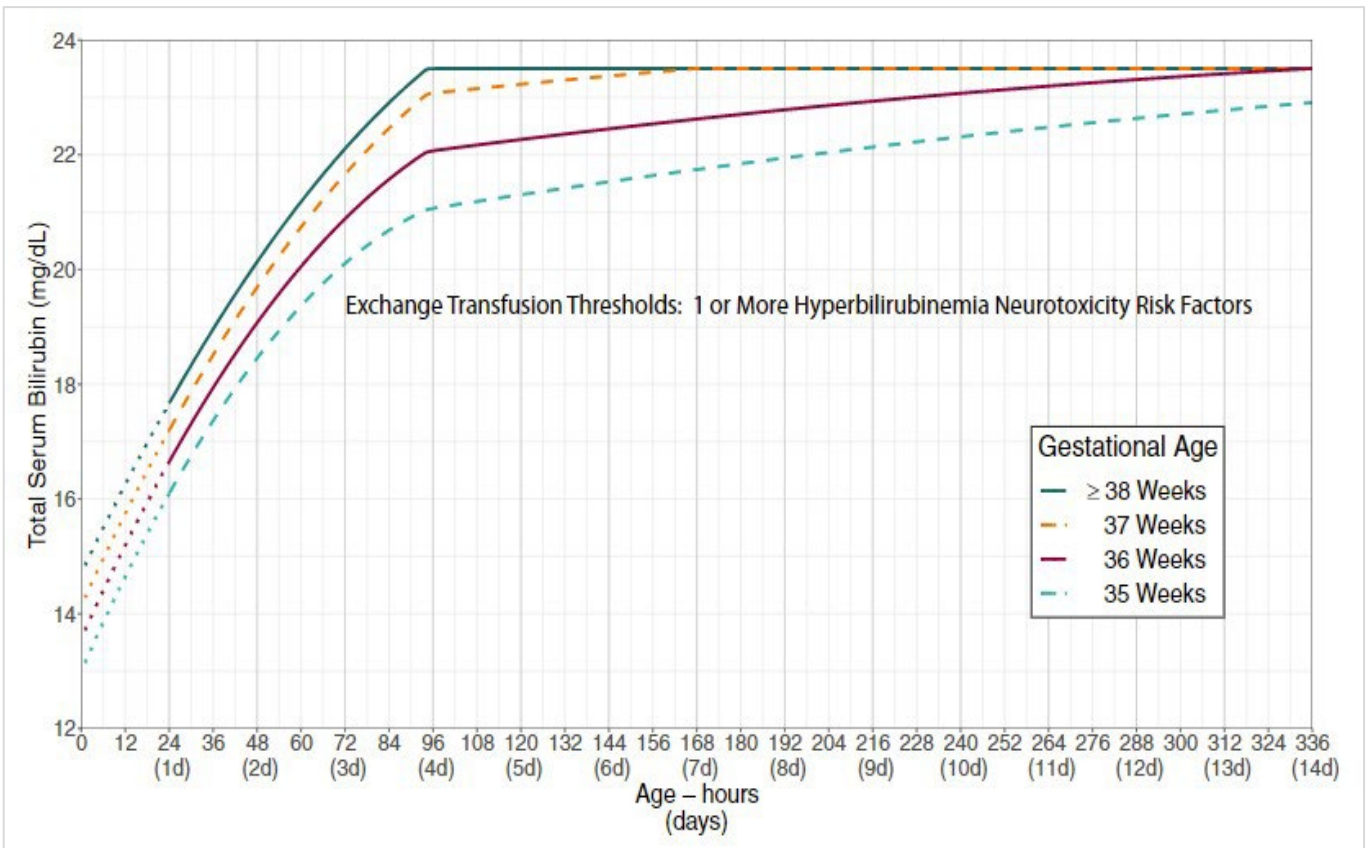




Exchange Transfusion Threshold Diagram

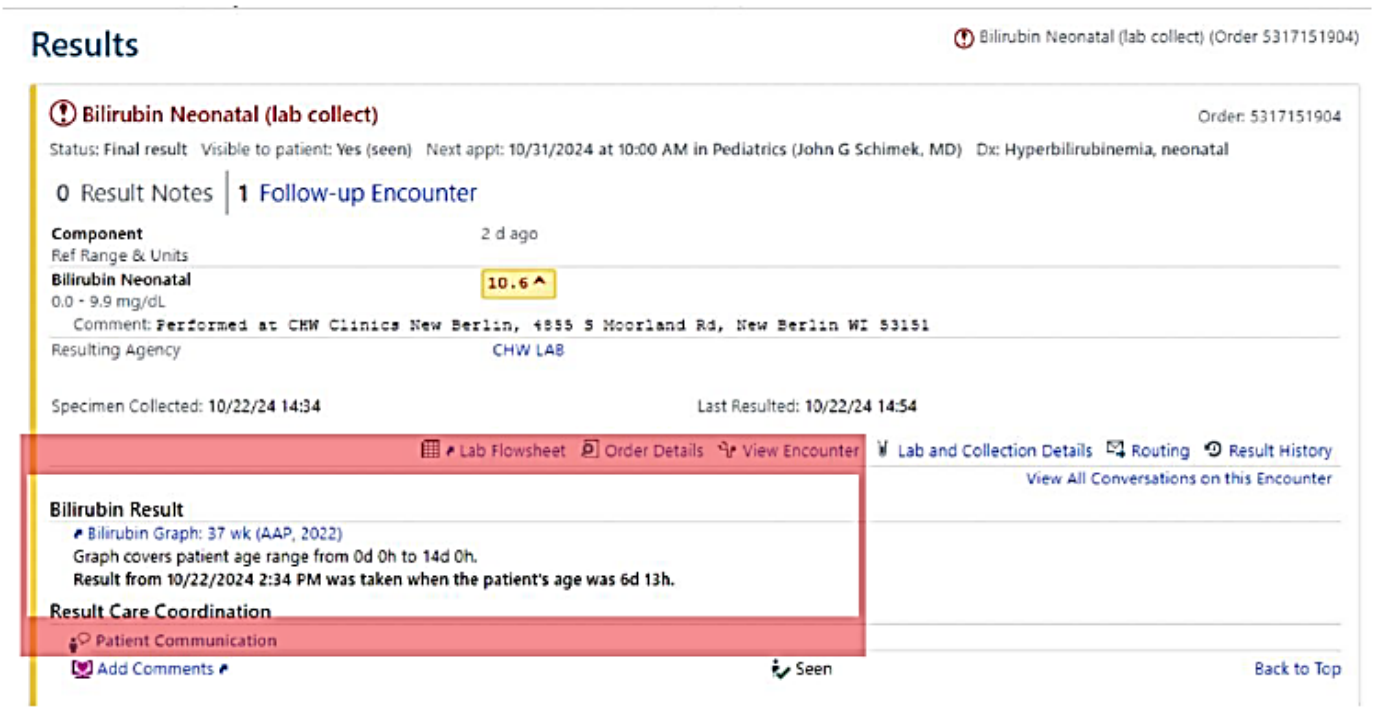
Use EPIC Embedded Bilitool for patient specific results



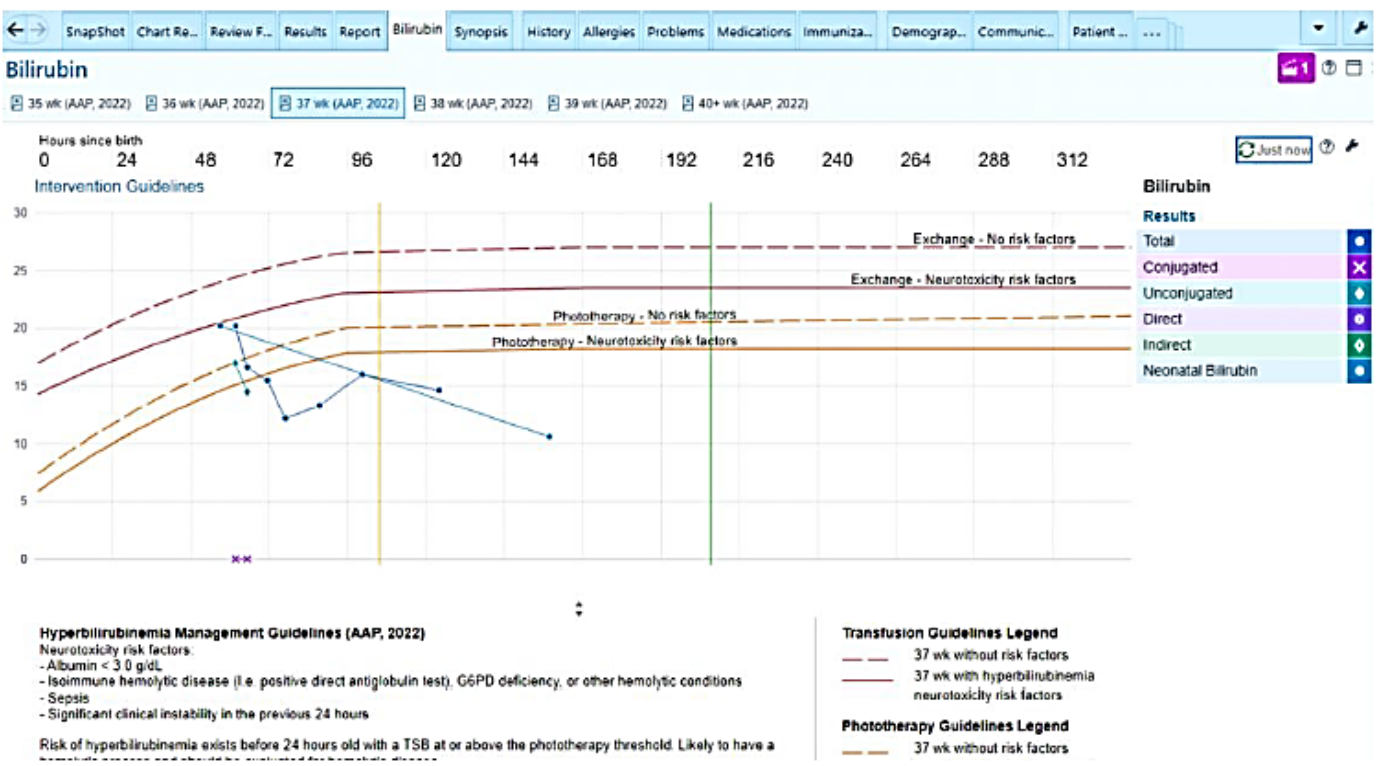


Epic Bilirubin Navigator

If reviewing a Lab either from the chart > Labs or the InBasket, within the report will be a hyperlink to open up the Bilirubin Navigator that plots out the Bilirubin lab tests. This navigator can be found for infants 0-14 days.



Clicking the hyperlink to go to the Bilirubin Graph reveals info below



Addendum A:
Weekend Process for Neonatal Bilirubin Checks

Day of planning:	Sign Out	Registration	Lab Order	Scheduling of labs
Friday discharge with Saturday labs	Birth Hospital contacts PCP office with weekend plan RN or MD accepts	Family contacts PCP office	PCP office is asked to place order or Birth Hospital Faxes order 414-266-2597 or Hospital sends paper order with family or Hospital completes lab requisition Children's Website	Central Scheduling 414-607-5280 (7:30 – 5:30) on Friday
Saturday discharge with Sunday labs	Hospital contacts PCP on call provider through triage for peds	Family can call 414-266-4950 (outpatient lab registration)	Birth Hospital Faxes order 414-266-2597 or Hospital sends paper order with family or Hospital completes lab requisition Children's Website	Schedule at time of registration
Saturday lab results requiring Sunday labs	N/A	N/A	PCP on call orders lab	Family can call 414-266-4950

Lab hours available at https://childrenswi.org/medical-care/laboratory-services. Contact lab at 414-266-2500 for holiday hours.

- **What if a family needs a phototherapy blanket on the weekend?**
  1. Place Epic order for phototherapy DME81
  2. Call Home Care Medical: 262-786-9870 F: 262-957-5535
     - Speak with respiratory (x208) to order bili blanket or bed. They will take a verbal order but need to fax order to them on Monday, send message to triage pool to fax order on Monday.
     - Expect delivery within 4 hrs. No insurance $50/day. Return within 36 hrs of d/c or be billed late fee $50.
  3. Other options
     - Oxygen One P: 262-521-2202 F: 262-521-2249
     - Aurora At Home (only babies born at Aurora) P: 800-862-2001 F: 414-327-6965
     - Contact Children's Wisconsin Case Management at (414-266-3680) for assistance

- **Be prepared to provide the following information when ordering phototherapy:**
  - Patient's name, address, home phone number, email address, DOB and diagnosis
  - Patient's insurance information (including group number and employer of policy holder)
  - Name and DOB of policy holder
  - Physician's name and email address
  - They may ask for chart notes and/or patients last bili level
  - ***D/C Bili Blanket:*** Phototherapy Discharge Fax order needs to be filled out, PCP signs and fax to DME Company

For more information on phototherapy, including educational resources for families, see the Phototherapy page in the Connect Primary Care team room under Clinical Resources.

Neonatal Hyperbilirubinemia Pathway

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Approved by: Hyperbilirubinemia Pathway Workgroup

Approved 03.28.2025 by UC, EDTC, CMG, NICU and Quality Department

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