

Routine Treatments



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Bob and Joan's Story

Tommy is going home from the hospital today. His nurse gives his parents, Bob and Joan, prescriptions for his new medicines. She also gives them a list of appointments Tommy needs. The nurse reminds Bob and Joan how to care for his new G-tube. She also tells them to make sure Tommy gets all his treatments. Bob asks, "Where are the equipment and supplies he needs?" "The home care supplier will bring everything to your home," the nurse says.

On the way home they stop at the pharmacy. "It will take a few hours to get the medicines ready," the clerk says. Once home Grandma says, "The home care supplier brought everything an hour ago." Bob and Joan see cases of formula stacked up next to a feeding pump and a wheelchair. There are bags and boxes of supplies everywhere. They wonder where they will put it all.

Bob and Joan think about the things they need to do each day: laundry, grocery shopping, cooking, driving kids, cleaning their home, helping with home work, giving baths, and more. Now they must find extra time to give Tommy the new medicines and tube feedings. They must stretch his muscles and take him to therapy and doctor visits too. They are worried about having time to do it all.

Joan notices they are late giving Tommy his medicines. Bob drives to the pharmacy and brings the medicines home. Joan gives Tommy his medicines. Then she remembers that one medicine can only be given after eating. She hopes she did not give that one by mistake. She's so tired. She can't even remember which ones she gave.

- What can they do to remember the treatments that Tommy needs?
- How can they keep track of treatments that have been given?

The next pages will give information about how to keep track of your child's treatments.



What's It All About

Children with health conditions often have special needs such as specialty doctors, medical tests, surgeries, overnight hospital stays and routine treatments.

Routine treatments are anything needed regularly to stay healthy. For example, breathing treatment, tube feeding, dressing change, lab test, therapy, medicine and special equipment. Keeping track of routine treatments helps you remember what to do and when. For example you may write a medicine list, feeding directions or therapy schedule.

Written schedules, lists and directions also help others caring for your child. You can be more certain that treatments will be given as prescribed when you are away.

Keeping track of tests, surgeries, and hospital stays will help you remember as your child gets older.

There's a lot to learn about your child's treatment and care. Be patient with yourself and learn from your mistakes. It will get easier with time.

Steps to Learn About Routine Treatments

1. Describe your child's routine treatments.
 - Know what treatments are needed.
 - Know why treatments are needed.
 - Keep track of treatments in writing.
 - Use schedules, logs and lists to help you remember.
2. Make sure your child gets treatments as prescribed.
 - Learn and teach others how to give treatments safely.
 - Use schedules, lists, and logs to tell others:
 - Supplies, equipment and other things needed.
 - When treatments are needed.
 - How to safely give treatments
 - Who can help and/or answer questions.
3. Keep your child's written medicine list up-to-date.
 - Write important information about medicines needed.
 - Bring the list to appointments and hospital stays.

Take Action

Talk with your health care providers.

Describe your child's routine treatments.

Others may help give treatments but you still must know:

- Name or type of treatment.
- Reason needed.
- When to give.
- How to safely give treatment.
- Equipment, supplies, or other things needed.
- Who prescribes the treatment.
- Who to call if you have questions.

Tell health care providers when you need help.

- Ask if you don't understand what to do.
- Talk with providers if treatments are regularly missed.
 - Ask what to do if a treatment is missed.
 - Ask if there is simpler schedule.
 - Ask what treatments should never be missed.
 - Ask what treatments could be missed sometimes.



What to Know About Medicines

Name of medicine.

Reason needed.

How and when to give.

Special directions.

Problems to watch for.

How long to take.

What to do if you forget to give it.

Doctor who prescribes.

Reasons to call a health care provider.

Where to get medicine.

Take Action

Talk with your health care providers.

Make sure that your child gets treatments as prescribed.

- Give written directions to anyone who helps give treatments.
- Show (demonstrate) how to give treatments.
- After teaching how to give a treatment, ask the person to show you.
- Tell caregivers how to contact you if they have questions.
- Make a plan for what to do if a regular caregiver is away or sick.

Keep track of your child's treatment in writing.

- Use schedules, lists, directions, and logs to:
 - Track treatments and any changes.
 - Tell others about treatments.
 - Make sure treatments are given as prescribed.
- Keep schedules, lists, and logs up to date.
- Bring lists, schedules, and logs to appointments and hospital stays.
- Make copies for healthcare providers. Always keep a copy for yourself.

Ways to Remember When to Give Treatment

Always do at same time of day.

Link treatment with something you always do such as eating dinner.

Use a reminder system:

- Set cell phone or watch alarm.
- Put reminder notes where you will easily see them.
- Ask pharmacy clerk if they have a reminder system.
- Sign up for text or email reminders.



Check Yourself

- I can describe the routine treatments my child needs:
 - Name or type of treatment.
 - Reason treatment is needed.
 - How to safely give treatment.

- I know how to make sure my child gets treatments as prescribed.
 - I have written information about my child's treatments.
 - I share written information with people caring for my child.
 - I ask health care providers when I have questions or problems giving treatments.

- I have written information about my child's treatments.

- I have a written list of my child's medicines:
 - I bring it to appointments and hospital stays.
 - I keep it up to date.



More Information and Resources

Your child's health care team is your best resource. Ask if you have questions.

Children's Hospital of Wisconsin Family Portal: Keep up-to-date medicine list and other health information for free on this website. See and print the information from any computer with internet access.

<https://familyportal.chw.org/>

MedAction Plan: Sign up for emails and/or text message reminders. Reminders help you remember when medicine is due and when to get a medicine refill.

<http://www.medactionplan.com/medactionplan/mymedschedule.asp>

Online Calendars: Keep track of your child's schedule on an online calendar. It can be seen and printed from any computer. Many online calendars are free and easy, such as Google calendar.

<http://www.google.com/calendar/>

KidsHealth: Find medicine information written for parents, kids, and teens.

<http://kidshealth.org/parent/medicines/index.html>

Medline Plus: Find medicine information in English and Spanish from this website.

<http://www.nlm.nih.gov/medlineplus/druginformation.html>

National Center for Complimentary and Alternative Medicine: Learn about alternative therapies from this website. Information is in English and Spanish.

<http://nccam.nih.gov/>

Lab Tests Online: Provides information about lab tests and results.

<http://www.labtestsonline.org/understanding/index.html>

Radiology Info: Learn about radiology tests. For example, ultrasounds, swallow studies, MRI, nuclear medicine tests, etc.

<http://www.radiologyinfo.org/>

Routine Treatments Forms

Form Name	How it can be used
Medicine List	<ul style="list-style-type: none"> • Use this form to keep track of medicines. • List prescription drugs. Include inhaled medicines and/or medicine only needed sometimes. • List over the counter drugs. For example, vitamins, herbs, and cold medicine. • Keep medicine list updated. Bring it to appointments and hospital stays.
Medicine Schedule	<ul style="list-style-type: none"> • Use this schedule to see what medicines are needed through the day. • Keep it in an easy to see place such as on a cabinet door or refrigerator.
Nutrition Summary	<ul style="list-style-type: none"> • Use this form to describe your child's diet (what they eat and drink). • There are three sections: eating by mouth, tube feeding, and IV nutrition or fluids. • Only complete the sections that describe your child's nutrition (diet).
Treatment and Therapy Calendar	<ul style="list-style-type: none"> • Use this calendar to see when treatment and therapy are scheduled. • Keep it in an easy to see place such as on a cabinet door or refrigerator.
Test Log	<ul style="list-style-type: none"> • Use this log to keep track of medical tests. For example, blood and urine lab tests, x-rays, MRI, CT scan, breathing test, EKG, or EEG.
Surgeries and Procedures	<ul style="list-style-type: none"> • Use this log to keep track of surgeries (operations) and other procedures.
Hospital Stays	<ul style="list-style-type: none"> • Use this log to keep track of hospital stays that last at least one day.
Appointments and Tests	<ul style="list-style-type: none"> • Use this form to keep track of tests and appointments needed regularly, for example, a test needed every year or a doctor visit needed every six months.
Therapy	<ul style="list-style-type: none"> • Use this schedule to keep track of therapy, for example, Physical Therapy (PT), Speech Therapy (ST), art therapy, behavioral therapy, or counseling.
Treatments	<ul style="list-style-type: none"> • Use this schedule to keep track of treatments, for example, oxygen, breathing treatment, dressing change, blood pressure check, or tube feeding.

Name: _____

Medicine List

Name		Date of Birth		Weight	kg
Drug Allergies					Latex Precautions <input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy #1		Phone		Fax	
Pharmacy #2		Phone		Fax	
Pharmacy #3		Phone		Fax	

Instructions: Use the form to keep track of prescription drugs, vitamins, herbal supplements, inhaled medicine, and over the counter drugs. Keep this form updated. Make sure to bring it to clinic or doctor visits and hospital admissions.

Medicine Name		How much (Dose)	Strength & Form	How to Give			Start
				Route	How often	When	
Who Prescribes	Pharmacy	Reason for Medicine		Special Directions / Things to Look For			Stop

Medicine Name		How much (Dose)	Strength & Form	How to Give			Start
				Route	How often	When	
Who Prescribes	Pharmacy	Reason for Medicine		Special Directions / Things to Look For			Stop

Medicine Name		How much (Dose)	Strength & Form	How to Give			Start
				Route	How often	When	
Who Prescribes	Pharmacy	Reason for Medicine		Special Directions / Things to Look For			Stop

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				Route	How often	When	
Who Prescribes	Pharmacy	Reason for Medicine		Special Directions / Things to Look For			Stop

Medicine Name		How much (Dose)	Strength & Form	How to Give			Start
				Route	How often	When	
Who Prescribes	Pharmacy	Reason for Medicine		Special Directions / Things to Look For			Stop

Name _____

Nutrition Summary

Date	Weight kg	Height cm	Date of Birth	
Allergies				
Eats by Mouth <input type="checkbox"/> yes <input type="checkbox"/> no (See below)		Tube Feeding <input type="checkbox"/> yes <input type="checkbox"/> no (See page 2)		IV Nutrition <input type="checkbox"/> yes <input type="checkbox"/> no (See page 3)
Special Diet By Mouth <input type="checkbox"/> yes <input type="checkbox"/> no (Leave this section blank if you child does not eat by mouth)				
Describe Special Diet				
Reason (Write why a special diet is needed)				
Supplies Used (Check all that apply) <input type="checkbox"/> Special Spoon <input type="checkbox"/> Special Cup <input type="checkbox"/> Special Bottle <input type="checkbox"/> Thickener				
<input type="checkbox"/> Other				
Special Directions and Notes (Write directions, tips, and other important things to know about diet)				
Who Prescribes	Provider Name	How Provider Helps	Phone	Fax
Dietician or Other Healthcare Provider				
Where to Get Special Nutrition				
Where to Get Equipment and Supplies				

Last Updated _____

Name _____

Nutrition Summary

Tube Feeding (Leave blank if your child doesn't get tube feedings)				
Type of Tube (Check all that apply) <input type="checkbox"/> NG <input type="checkbox"/> G-tube <input type="checkbox"/> G-J-tube <input type="checkbox"/> NJ <input type="checkbox"/> J-tube				
Reason (Write why tube feeding is needed)				
Formula or Special Food	How Much (Each day)	How to Give Tube Feeding		
		Rate (Choose one)	How Often	When (What time)
	_____ ml/day	<input type="checkbox"/> Bolus ml at ml/hr	<input type="checkbox"/> _____ times/day	
	_____ cans/day	<input type="checkbox"/> Continuous ml at ml/hr	<input type="checkbox"/> every _____ hours	
			<input type="checkbox"/> 24 hours/day	
			<input type="checkbox"/> _____ hours/day	
Supplies Needed (Check all that apply) <input type="checkbox"/> Feeding Bags _____ <input type="checkbox"/> Tubing _____ <input type="checkbox"/> Extension Sets _____				
<input type="checkbox"/> Syringe(s) (Write the sizes used) _____ <input type="checkbox"/> Feeding Pump (Write the type) _____				
<input type="checkbox"/> Backpack <input type="checkbox"/> IV Pole <input type="checkbox"/> Batteries <input type="checkbox"/> Other _____				
Special Directions and Notes (Write directions, tips, routines, and other important things to know about diet)				
	Provider Name	How Provider Helps	Phone	Fax
Who Prescribes				
Dietician or Other Healthcare Provider				
Where to Get Special Nutrition				
Where to Get Equipment and Supplies				

Last Updated _____

Name _____

Nutrition Summary

Intravenous (Leave blank if your child does not get IV nutrition)				
Please ask doctor, nurse, or pharmacist for a copy of the newest order.				
IV Type <input type="checkbox"/> PICC line <input type="checkbox"/> Central line- Port <input type="checkbox"/> Central line- Broviac or Hickman <input type="checkbox"/> Other IV Access				
Reason (Write why IV nutrition is needed)				
IV Nutrition or Fluid	How Much (Each day)	Rate (Choose one)	How Often	When (What Time)
<input type="checkbox"/> TPN	_____ ml/day	<input type="checkbox"/> Continuous ml at ml/hr	<input type="checkbox"/> 24 hours/day <input type="checkbox"/> _____ hours/day	
<input type="checkbox"/> IV fluids	_____ ml/day	<input type="checkbox"/> Bolus ml at ml/hr	<input type="checkbox"/> _____ times/day <input type="checkbox"/> every _____ hours	
		<input type="checkbox"/> Continuous ml at ml/hr	<input type="checkbox"/> 24 hours/day <input type="checkbox"/> _____ hours/day	
<input type="checkbox"/> Lipids	_____ ml/day	<input type="checkbox"/> Bolus ml at ml/hr	<input type="checkbox"/> _____ times/day <input type="checkbox"/> every _____ hours	
Equipment and Supplies Used (Check all that apply) <input type="checkbox"/> Batteries <input type="checkbox"/> Extension Sets <input type="checkbox"/> Filters <input type="checkbox"/> Alcohol Wipes				
<input type="checkbox"/> Tubing _____ <input type="checkbox"/> Needles (size used) _____				
<input type="checkbox"/> IV Pump (type) _____ <input type="checkbox"/> Syringes (size used) _____ <input type="checkbox"/> Other _____				
Special Directions and Notes (Write directions, tips, other important things to know about diet)				
	Provider Name	How Provider Helps	Phone	Fax
Who Prescribes				
Dietician or Other Healthcare Provider				
Where to Get Special Nutrition				
Where to Get Equipment and Supplies				

Last Updated _____

Name _____

Treatment and Therapy Schedule

Use this calendar to see when treatments and therapy are scheduled. Keep it where it is easy to see such as a cabinet door or the refrigerator.

Time of Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Appointments and Tests

Use this form to keep track of tests and appointments needed regularly, for example, a yearly blood test.

What needs to be done?	Reason? <i>Why it's needed regularly</i>	How often? When?	Where to go? Who to see? Phone number	Referral Needed? Who to ask for referral?	Notes
<p>Example:</p> <p><i>Check up with Bone Doctor</i></p>	<p><i>Scoliosis</i></p> <p><i>Check brace and get back x-rays</i></p>	<p><i>Every 3 months: Feb., May, Aug., and Nov.</i></p>	<p><i>Dr. Femur in the Bone Clinic</i></p> <p><i>555-222-3333</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>From pediatrician</i></p>	<p><i>Need to get new prescription for new braces.</i></p> <p><i>Remember to bring report from PT.</i></p>
				<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
				<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
				<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Appointments and Tests

What needs to be done?	Reason? <i>Why it's needed regularly</i>	How often? When?	Where to go? Who to see? Phone number	Referral Needed? Who to ask for referral?	Notes
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Therapy

Use this form to keep track of therapies. Therapies may include Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT), behavioral therapy, and/or counseling.

Therapy	Reason	How often? When?	Who provides? Where to go? Phone Number	Doctor who prescribes?	Start Date Stop Date	Notes
<i>Example: Physical Therapy</i>	<i>Low muscle tone/ weakness</i>	<i>Mon. and Thurs. mornings</i>	<i>Missy Strong At school 555-111-2222</i>	<i>Pediatrician</i>	<i>Since age 3</i>	<i>Put leg braces on before therapy. Do home exercises every day</i>

Name _____

Therapy

Therapy	Reason	How often? When?	Who provides? Where to go? Phone Number	Doctor who prescribes?	Start Date Stop Date	Notes

Treatments

Use this form to keep track of therapies. Therapies may include Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT), behavioral therapy, and/or counseling.

Treatment	Reason	How often? When?	Who provides? Where to go? Phone Number	Doctor who prescribes?	Start Date Stop Date	Notes
<i>Example: Check blood pressure and heart rate.</i>	<i>Has high blood pressure. Need to keep an eye on it.</i>	<i>Before getting blood pressure medicine.</i>	<i>At home.</i>	<i>Dr. Kid Knee</i>	<i>Age 2</i>	<i>Take blood pressure on left arm. If it is too low or high wait 5 minutes and take it again.</i>

Name _____

Treatments

Treatment	Reason	How often? When?	Who provides? Where to go? Phone Number	Doctor who prescribes?	Start Date Stop Date	Notes