

Date: [Date]

To: Hospital Pharmacy Department / Nursing Administration

Facility Name: [Hospital Name]

RE: Pediatric Weight-Based Dosage Authorization

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/MRN: [Medical Record Number]

Admission Date: [Date]

Current Documented Weight: [Weight in kg] kg

Weight Date: [Date Measured]

To Whom It May Concern,

I, [Physician Name], hereby authorize the administration of medications for the above-named pediatric patient based on the verified weight of [Weight in kg] kg. All pharmacological interventions, including maintenance fluids, emergency medications, and therapeutic agents, must be calculated using this documented weight unless a clinical change requires a re-weigh.

Specific Instructions:

- All dosages must be cross-checked by two licensed clinicians.
- Standard pediatric dosing protocols for [Department Name, e.g., PICU] apply.
- Maximum dosages should not exceed the standard adult dose for any medication.

This authorization remains valid for the duration of the current inpatient admission unless superseded by a new clinical order.

Sincerely,

Physician Signature

Physician Name: [Print Name]

NPI Number: [NPI Number]

Contact Number: [Phone Number]