Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Saline Challenge Test

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. For testing patients with suspected hyperaldosteronism.
3. Exclusion criteria:
    - Potassium level less than 3.5 mmol/L
    - Blood pressure greater than or equal to 160/90 mmHg.

LABS:

- ☐ Basic Metabolic Set, Routine, ONCE,
- ☐ Renin (plasma), Routine, ONCE. Draw baseline while patient is seated upright.
- ☐ Aldosterone (serum), Routine, ONCE. Draw baseline while patient is seated upright.
- ☐ Renin (plasma), Routine, ONCE. Draw post infusion while patient is seated upright.
- ☐ Aldosterone (serum), Routine, ONCE. Draw post infusion while patient is seated upright.

NURSING ORDERS:

1. TREATMENT PARAMETER - Prior to testing, check potassium level. Notify MD and postpone testing if potassium level is less than 3.5 mmol/L.
2. Draw baseline renin and aldosterone while patient is seated upright.
3. Infuse 2 liters of Normal Saline over 4 hours while patient is seated upright (may get up to go to the bathroom).
4. TREATMENT PARAMETER - Check blood pressure every 30 minutes. Call MD if blood pressure is greater than or equal to 160/90 mmHg.
5. Draw post infusion renin and aldosterone while the patient is seated upright.

MEDICATIONS:

sodium chloride 0.9 %, 2 L, intravenous, ONCE over 4 hours while patient is seated upright (may get up to go to the bathroom).

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders