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

PO7071

ADULT AMBULATORY INFUSION ORDER

Hydration with Electrolytes

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. Please select from standard replacement bags or custom IV fluid. If ordering custom fluid, please specify base fluid, additives, total volume, and rate.

LABS:

- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

MEDICATIONS:

Standard Electrolyte Replacement:

- ☐ Calcium gluconate 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min
- ☐ Calcium gluconate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min

- ☐ Magnesium sulfate 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 30 min
- ☐ Magnesium sulfate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 1 hour
- ☐ Magnesium sulfate 4 gram in sodium chloride 0.9% 100 mL IV, ONCE over 2 hours

Potassium Chloride

- ☐ 20 mEq IV via CENTRAL LINE over 2 hours, in sodium chloride 0.9% 100 mL
- ☐ 20 mEq IV via PERIPHERAL LINE over 2 hours, in sodium chloride 0.9% 250 mL
- ☐ 40 mEq IV via CENTRAL LINE over 4 hours, in sodium chloride 0.9% 250 mL
- ☐ 40 mEq IV via PERIPHERAL LINE over 4 hours, in sodium chloride 0.9% 500 mL

Interval: (must check one; note PRN orders must include PRN indication)

- ☐ ONCE
- ☐ Repeat every _____ days for x _____ doses
- ☐ Repeat every _____ weeks for x _____ doses
- ☐ Other: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Custom IV Fluid

Base: ***(must check one)***

- ☐ Dextrose 5%
- ☐ Dextrose 5%-sodium chloride 0.45%
- ☐ Dextrose 5%- sodium chloride 0.9%
- ☐ Sodium chloride 0.45%
- ☐ Sodium chloride 0.9%
- ☐ Lactated Ringers

Additives:

- ☐ Calcium gluconate: _____ mg
- ☐ Magnesium sulfate: _____ mg
- ☐ Potassium acetate: _____ mEq
- ☐ Potassium chloride: _____ mEq
- ☐ Potassium phosphate: _____ mMol
- ☐ Sodium acetate: _____ mEq
- ☐ Sodium bicarbonate 8.4%: _____ mEq
- ☐ Sodium phosphate: _____ mMol

Other (Micronutrients):

- ☐ Thiamine 100 mg IV over 1 hour
- ☐ Multivitamin (adult, with vitamin K) 10 mL IV over 2 hours
- ☐ Folic Acid 1 mg IV over 1 hour
- ☐ Folic Acid 1 mg and thiamine 100 mg IV over 1 hour
- ☐ Folic Acid 1 mg, thiamine 100 mg, and Multivitamin (adult, with vitamin K) 10 mL IV over 2 hours

Total volume: ***(must check one)***

- ☐ 1000 mL
- ☐ _____ mL

Rate: ***(must check one)***

- ☐ 50 mL/hr
- ☐ 75 mL/hr
- ☐ 100 mL/hr
- ☐ 125 mL/hr
- ☐ 250 mL/hr
- ☐ 500 mL/hr
- ☐ 1,000 mL/hr
- ☐ _____ mL/hr

Interval: ***(must check one; note PRN orders must include PRN indication)***

- ☐ ONCE
- ☐ Repeat every ____ days for x _____ doses
- ☐ Repeat every ____ weeks for x _____ doses
- ☐ Other: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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