



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

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Hydration for  
Hyperemesis Gravidarum**

Page 1 of 3

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 specify base fluid, additives, total volume, and rate.

**LABS COMPLETED:** \_\_\_\_\_

**ADDITIONAL LABS:**

- CMP, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- CBC with differential, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- Urine Dipstick, Ketones, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*

**MEDICATIONS:**

**Bag 1**

**Base: (must check one)**

- D5LR (Dextrose 5% – Lactated Ringers)
- LR (Lactated Ringers)
- D5-1/2NS (Dextrose 5% – sodium chloride 0.45%)
- NS (sodium chloride 0.9%)

**Additives:**

- Folic acid 1 mg
- Multivitamin (adult, with vitamin K), 10 mL, Infuse at least over 2 hours
- Potassium chloride \_\_\_\_\_ mEq/L (Max dose is 40 mEq in 1 liter), Infusion rate is 10 mEq/hr

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

- 250 mL
- 500 mL
- 1000 mL
- \_\_\_\_\_ mL

**Rate: (must check one)**

- 250 mL/hr
- 500 mL/hr
- 1000 mL/hr
- 2000 mL/hr
- \_\_\_\_\_ mL/hr

**Interval: (must check one)**

- ONCE
- Every visit
- Repeat every \_\_\_\_\_ days for x \_\_\_\_\_ doses
- Repeat every \_\_\_\_\_ weeks for x \_\_\_\_\_ doses
- Other: \_\_\_\_\_



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**Bag 2: (additional hydration)**

**Base: (must check one)**

- D5LR (Dextrose 5% – Lactated Ringers)
- LR (Lactated Ringers)
- D5-1/2NS (Dextrose 5% – sodium chloride 0.45%)
- NS (sodium chloride 0.9%)

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

- 250 mL
- 500 mL
- 1000 mL
- \_\_\_\_\_ mL

**Rate: (must check one)**

- 250 mL/hr
- 500 mL/hr
- 1000 mL/hr
- 2000 mL/hr
- \_\_\_\_\_ mL/hr

**Interval: (must check one)**

- Every visit with bag 1
- Other: \_\_\_\_\_

**AS NEEDED MEDICATIONS:**

**Antiemetics:**

- metoclopramide (REGLAN) injection 10 mg, IV, AS NEEDED x1 dose for nausea/vomiting
- ondansetron (ZOFTRAN) injection 4 mg, IV, AS NEEDED, x 1 dose for nausea/vomiting
- promethazine (PHENERGAN) 12.5 mg, IV, AS NEEDED for nausea/vomiting

**Histamine (H<sub>2</sub>) blockers**

- famotidine (PEPCID) 20 mg, IV, AS NEEDED x1 dose
- Cimetidine HCl (TAGAMET) 300 mg IV, AS NEEDED x1 dose, over 15-20 minutes

**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: \_\_\_\_\_



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*Patient Identification*

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OLC Central Intake Nurse:

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](http://www.ohsuknight.com/infusionorders)