ADULT AMBULATORY INFUSION ORDER

Hydration with Electrolytes

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 NaCl 50 mL IV, ONCE over 20-40 min
☐ Calcium gluconate 2 gram in NaCl 50 mL IV, ONCE over 20-40 min

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

☐ Potassium Chloride 20 mEq in NaCl 0.9% 100 mL IV ONCE over 2 hours via CENTRAL LINE
☐ Potassium Chloride 20 mEq in NaCl 0.9% 250 mL IV ONCE over 2 hours via PERIPHERAL LINE
☐ Potassium Chloride 40 mEq in NaCl 0.9% 250 mL IV ONCE over 4 hours via CENTRAL LINE
☐ Potassium Chloride 40 mEq in NaCl 0.9% 500 mL IV ONCE over 4 hours via PERIPHERAL LINE

Interval: (must check one)

☐ ONCE
☐ Every visit x __________ doses
☐ Repeat every ________ days for x ________ doses
☐ Repeat every ________ weeks for x ________ doses
☐ Other: ____________________________
Custom IV Fluid

Base: (must check one)
- ✔️ Dextrose 5%
- ✔️ Dextrose 5%-NaCl 0.45%
- ✔️ Dextrose 5%-NaCl 0.9%
- ✔️ NaCl 0.45%
- ✔️ NaCl 0.9%
- ✔️ Lactated Ringers

Additives:
- ✔️ Calcium gluconate: ________ mg
- ✔️ Magnesium sulfate: ________ mg
- ✔️ Potassium acetate: ________ mEq
- ✔️ Potassium chloride: ________ mEq
- ✔️ Sodium acetate: ________ mEq
- ✔️ Sodium bicarbonate 8.4%: ________ mEq
- ✔️ Sodium phosphate: ________ mMol

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
- ✔️ ________ mL/hr

Interval: (must check one)
- ✔️ ONCE
- ✔️ Every visit x _____ doses
- ✔️ Repeat every ___ days for x ________ doses
- ✔️ Repeat every ___ weeks for x ________ doses
- ✔️ Other: ________________________________

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

Interval: (must check one)
- ✔️ ONCE
- ✔️ Every visit x _____ doses
- ✔️ Repeat every ___ days for x ________ doses
- ✔️ Repeat every ___ weeks for x ________ doses
- ✔️ Other: ________________________________
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.

<table>
<thead>
<tr>
<th>Provider signature: __________________________</th>
<th>Date/Time: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name: ______________________________</td>
<td>Phone: ______________________________</td>
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</tbody>
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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