**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 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

**Interval: (must check one)**

- ☐ ONCE
- ☐ Every visit x _____ doses
- ☐ 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%-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
- ☐ Potassium phosphate: _____ mMol
- ☐ 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: _____

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**: _____

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