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

**NURSING ORDERS:**

1. TREATMENT PARAMETER – Notify provider if urine ketones are greater than trace or orthostatic blood pressure changes are greater than 20 mmHg after 3 liters of IV hydration.
**ADULT AMBULATORY INFUSION ORDER**

**Hydration for Hyperemesis Gravidarum**

**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: _______________________________________

**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 (specify 1st, 2nd, or 3rd line for each PRN medication)

☐ ondansetron (ZOFRAN) injection 4 mg, IV, AS NEEDED, x 1 dose for nausea/vomiting

Choose order of preferred administration: 1st line____2nd line____3rd line____

☐ prochlorperazine (COMPAZINE) injection 10 mg, IV, AS NEEDED, x 1 dose for nausea/vomiting

Choose order of preferred administration: 1st line____2nd line____3rd line____

☐ metoclopramide (REGLAN) injection 10 mg, IV, AS NEEDED x1 dose for nausea/vomiting

Choose order of preferred administration: 1st line____2nd line____3rd line____

Histamine (H2) blockers

☐ famotidine (PEPCID) 20 mg, IV, AS NEEDED x1 dose for heartburn/indigestion

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

- **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

- **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

- **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