ADULT AMBULATORY INFUSION ORDER

Hydration with Electrolytes

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

Weight: __________ kg  Height: __________ cm

Allergies: ________________________________________________________________

Diagnosis Code: __________________________ 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
- □ 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)**
- □ 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.

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