ADULT AMBULATORY INFUSION ORDER
Hydration with Electrolytes

**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 sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min
- Calcium gluconate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min
- Magnesium sulfate 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 30 min
- Magnesium sulfate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 1 hour
- Magnesium sulfate 4 gram in sodium chloride 0.9% 100 mL IV, ONCE over 2 hours

Potassium Chloride
- 20 mEq IV via CENTRAL LINE over 2 hours, in sodium chloride 0.9% 100 mL
- 20 mEq IV via PERIPHERAL LINE over 2 hours, in sodium chloride 0.9% 250 mL
- 40 mEq IV via CENTRAL LINE over 4 hours, in sodium chloride 0.9% 250 mL
- 40 mEq IV via PERIPHERAL LINE over 4 hours, in sodium chloride 0.9% 500 mL

**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%-sodium chloride 0.45%
- Dextrose 5%- sodium chloride 0.9%
- Sodium chloride 0.45%
- Sodium chloride 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: __________

Central Intake:
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