| | |
|---|---|
| **Oregon Health & Science University Hospital and Clinics Provider's Orders**<br>PO7071<br>ADULT AMBULATORY INFUSION ORDER<br>**Hydration for Hyperemesis Gravidarum**<br>Page 1 of 4 | ACCOUNT NO.<br>MED. REC. NO.<br>NAME<br>BIRTHDATE<br>*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 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 **( > 5 mg/dL)** or orthostatic blood pressure changes are greater than 20 mmHg after 3 liters of IV hydration.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

*Patient Identification*

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

**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
- ☐ _____ 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
- ☐ _____ mL/hr

**Interval:** ***(must check one)***

- ☐ Every visit with bag 1
- ☐ Other: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

*Patient Identification*

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

**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 ($H_2$) 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**: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

*Patient Identification*

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

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