



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Hydration with Electrolytes

Page 1 of 3

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:

- | | |
|---|---|
| <input type="checkbox"/> CMP, Routine, ONCE | every _____ (visit)(days)(weeks)(months) – Circle One |
| <input type="checkbox"/> CBC with differential, Routine, ONCE | every _____ (visit)(days)(weeks)(months) – Circle One |
| <input type="checkbox"/> Magnesium (Plasma), Routine, ONCE | every _____ (visit)(days)(weeks)(months) – Circle One |
| <input type="checkbox"/> Phosphorous (Plasma), Routine, ONCE | every _____ (visit)(days)(weeks)(months) – Circle One |
| <input type="checkbox"/> Labs already drawn. Date: _____ | |

MEDICATIONS:

Standard Electrolyte Repletion

Pharmacist to select appropriate admixture options including (as applicable) formulation, fluid base type, volume, concentration, administer-over time, and rate according to the package insert, drug information references, and facility policies, procedures, and practice standards.

- | | |
|--|---|
| <input type="checkbox"/> calcium gluconate IV 1 gram | <input type="checkbox"/> potassium chloride 20 mEq |
| <input type="checkbox"/> calcium gluconate IV 2 grams | <input type="checkbox"/> potassium chloride 40 mEq |
| <input type="checkbox"/> magnesium sulfate IV 2 gram | <input type="checkbox"/> potassium phosphate 15 mmol |
| <input type="checkbox"/> magnesium sulfate IV 4 grams | <input type="checkbox"/> potassium phosphate 30 mmol |
| <input type="checkbox"/> sodium phosphate IV 30 mmol | |
| <input type="checkbox"/> sodium phosphate IV 40 mmol | |
| <input type="checkbox"/> sodium bicarbonate IV 100 mEq | |
| <input type="checkbox"/> sodium bicarbonate IV 150 mEq | |

Facility will select appropriate line for potassium infusions based on patient's vascular access unless specified below (optional):

- Central line
- Peripheral line

Interval: (must check one; note PRN orders must include PRN indication)

- ONCE
- Repeat every _____ days for _____ doses
- Repeat every _____ weeks for _____ doses
- Other: _____



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Custom IV Fluid

Base: (must check one)

- Sodium chloride 0.9%
- Dextrose 5%
- Dextrose 5% – sodium chloride 0.9%
- Lactated Ringers

Other (Micronutrients):

- Thiamine 100 mg
- Multivitamin (adult, with vitamin K) 10 mL (duration selected below must be at least 2 hours)
- Folic Acid 1 mg

Volume: (must check one)

- 1000 mL
- _____ mL

Duration: (must check one)

- Over 30 minutes
- Over 1 hour
- Over 2 hours
- Over _____

Interval: (must check one; note PRN orders must include PRN indication)

- ONCE
- Repeat every _____ days for _____ doses
- Repeat every _____ weeks for _____ 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: _____



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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