Hydration for Hyperemesis Gravidarum

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 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 – If UA dipstick ordered, notify provider if urine ketones are greater than trace (greater than 5 mg/dL).
2. TREATMENT PARAMETER – If 3 liters of IV hydration is ordered, notify provider of orthostatic blood pressure changes are greater than 20 mmHg after administration.

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MEDICATIONS:

Custom IV Fluid (for stock hydration without additive, see below)

Base: ***(must check one)***
- ☐ D5LR (Dextrose 5% – Lactated Ringers)
- ☐ LR (Lactated Ringers)
- ☐ NS (sodium chloride 0.9%)

Additives:
- ☐ Folic acid 1 mg over 1 hour
- ☐ 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

Interval: ***(must check one; note PRN orders must include PRN indication)***
- ☐ ONCE
- ☐ Repeat every ____ days for x _____ doses
- ☐ Repeat every ____ weeks for x _____ doses
- ☐ Other: _____

Stock Hydration (without additive)

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; note PRN orders must include PRN indication)***
- ☐ ONCE
- ☐ Repeat every ____ days for x _____ doses
- ☐ Repeat every ____ weeks for x _____ doses
- ☐ Other: _____

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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

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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