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

PO7071

ADULT AMBULATORY INFUSION ORDER

Hydration with Electrolytes

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:

- ☐ CMP, Routine, ONCE — every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CBC with differential, Routine, ONCE — every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Magnesium (Plasma), Routine, ONCE — every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Phosphorous (Plasma), Routine, ONCE — every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ 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.

- ☐ calcium gluconate IV 1 gram
- ☐ calcium gluconate IV 2 grams

- ☐ magnesium sulfate IV 2 gram
- ☐ magnesium sulfate IV 4 grams

- ☐ sodium phosphate IV 30 mmol
- ☐ sodium phosphate IV 40 mmol

- ☐ sodium bicarbonate IV 100 mEq
- ☐ sodium bicarbonate IV 150 mEq

- ☐ potassium **chloride** 20 mEq
- ☐ potassium **chloride** 40 mEq
- ☐ potassium **phosphate** 15 mmol
- ☐ potassium **phosphate** 30 mmol

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: _____

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*);

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NAME
BIRTHDATE

Patient Identification

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

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