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

PO7071

ADULT AMBULATORY INFUSION ORDER

Hydration (Electrolytes and Antiemetics)

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. Hydration orders: Hydration orders are defaulted to 1000 mL bolus administered over 60-minutes. Provider must change order to specify different total volumes and rate if desired. Note: maximum allowable rate of 1000 mL/ 1 hour.
3. Hydration orders with additive: Standard infusion times are set, however provider must indicate base desired volume.
4. Antiemetic PRN medication options: plan defaults with PRN ondansetron PO & IV as first line options for nausea/vomiting. If multi-modal approach is desired, provider to select additional agents and delegate order of administration for all PRN nausea/vomiting indications (e.g. first-line, second-line, as part of multimodal plan, etc).

LABS:

- ☑ CMP, Routine, ONCE — every 1 week until discontinued
- ☐ CBC with differential, Routine, ONCE — every 1 week until discontinued
- ☐ 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:

Fluids (default orders, for custom fluids see below)

☐ sodium chloride 0.9 % bolus 1,000 mL, intravenous, administer over 60 Minutes,
Interval [must circle one]: (Once) or every_____ (visit)(days)(weeks)(months)

☐ lactated ringers (LR) bolus 1,000 mL, intravenous, administer over 60 Minutes,
Interval [must circle one]: (ONCE) or every_____ (visit)(days)(weeks)(months)

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Custom Fluids (stock hydration without additive)

Base (must check one):	**Total Volume (must check one):**
☐ sodium chloride 0.9 % (NS) ☐ lactated ringers (LR)	☐ 500 mL ☐ 2000 mL ☐ _____ mL
Rate (must check one):	**Interval (must check one):**
☐ 250 mL/hr ☐ 500 mL/hr ☐ _____ mL/hr Note: MAX rate: 1000 mL/hr	☐ ONCE ☐ Repeat every ____ days for x____ doses ☐ Repeat every ____ weeks for x____ doses ☐ Other: _____ Note: PRN orders must include PRN indication

Micronutrients

☑ GUIDELINES FOR ORDERING - Micronutrient bags default to NS base. If modifications or customizations are desired, provider to update order.

☐ folic acid 1 mg, thiamine 100 mg, multivitamin (adult, with vitamin K) 10 mL in sodium chloride 0.9 %, intravenous, administer over 2 hours
Interval [must circle one]: (ONCE) or every_____ (visit)(days)(weeks)(months)

☐ multivitamin (adult, with vitamin K) 10 mL in sodium chloride 0.9 %, intravenous, administer over: 2 Hours
Interval [must circle one]: (ONCE) or every_____ (visit)(days)(weeks)(months)

☐ thiamine 100 mg in sodium chloride 0.9 %, intravenous, administer over 0.5 Hours
Interval [must circle one]: (ONCE) or every_____ (visit)(days)(weeks)(months)

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Electrolyte Order Groups – Provider to check box for desired electrolyte repletion order group and fill out all required fields (bolded and underlined).

☐ **Electrolytes – Magnesium Sulfate (Fixed Dosing/Schedule)**

- **GUIDELINES FOR ORDERING**: Magnesium 1 g is not routinely available at infusion sites. Orders are available in 2 g and 4 g increments.
- **LABS**: MAGNESIUM, PLASMA, Normal, Clinic Collect, Blood, PRN if labs not drawn or resulted in 7 days.
- **TREATMENT PARAMETERS**: Fixed dosing with treatment parameters required as specified:
  - Transfusion parameters: **For magnesium level less than ___ mg/dL (within 7 days)**; administer magnesium sulfate IV.
  - If labs are not available within specified timeframe, RN to release magnesium lab.
- **NURSING COMMUNICATION**: Okay to start magnesium repletion (as ordered) while waiting for lab results if drawn at visit? **Yes/No – *Must Circle One***
  If labs result and magnesium is > 2.6 mg/dL, stop infusion.
- **MEDICATION:** Magnesium sulfate in sterile water IV, intravenous, ONCE, Infusion rate NTE 2 gram/hour.

Dose (must check one):	**Interval (must check one):**
❑ 2 grams	❑ ONCE
❑ 4 grams	❑ Repeat every _____ days for _____ doses
❑ 6 grams	❑ Repeat every _____weeks for x _____ doses
❑ 8 grams	❑ Other: _____

☐ **Electrolytes – Magnesium Sulfate (Standing Orders)**

- **GUIDELINES FOR ORDERING**: Magnesium 1 g is not routinely available at infusion sites. Orders are available in 2 g and 4 g increments.
- **LABS**: MAGNESIUM, PLASMA, Normal, Clinic Collect, Blood, Routine
- **NURSING COMMUNICATION**: Okay to start magnesium 2 gram repletion while waiting for lab results drawn at visit? **Yes/No – *Must Circle One***
  If labs result and magnesium is 2.6 mg/dL or greater, stop infusion.
- **MEDICATION**: Magnesium sulfate in sterile water IV, 2 g, intravenous, ONCE AS NEEDED if okay to start while waiting for lab results. Infusion rate NTE 2 gram/hour.
- **TREATMENT PARAMETERS**: RN to update medication order below based on lab value as below and administer sliding scale dosing based on reference range:
  - If Mg is </= 1.2 mg/dL administer total dose of Magnesium 8 grams: magnesium 4 gram IV in sterile water 100 mL RTU every 2 hours x2 doses
  - If Mg 1.3-1.5 mg/dL administer Magnesium 4 grams IV in sterile water 100 mL RTU over 2 hours
  - If Mg 1.6-1.8 mg/dL administer Magnesium 2 grams IV in sterile water 50 mL RTU once over 1 hour
- **MEDICATION**: Magnesium sulfate in sterile water IV, intravenous, ONCE, Infusion rate NTE 2 gram/hour. **Interval [must circle one]: (ONCE) or every_____(visit)(days)(weeks)(months)**

☐ **Electrolytes – Potassium Chloride (PRN Standing Orders)**

- **TREATMENT PARAMETERS**: RN to update medication order below based on lab value as below and administer sliding scale dosing based on reference range:
  - If K </= 3 mmol/L administer total dose of 40 mEq IV over 4 hours
  - If K 3.1-3.5 mmol/L administer total dose 20 mEq IV over 2 hours
- **MEDICATION:** potassium chloride in sterile water (peripheral), intravenous, administer over 1-6 hours, **Interval [must circle one]: (Once) or every ___(visit)(days)(weeks)(months)**
- **PROVIDER TO PHARMACIST COMMUNICATION**: Pharmacist okay to concentrate orders to 20 mEq/100 mL for patients with central line.

☐ **Electrolytes – Sodium Phosphate (Fixed Dosing/Schedule)**

- **GUIDELINES FOR ORDERING**:
  - Phosphorous (plasma) lab results are not available on the same day at all infusion locations. Patients who are being evaluated for phosphate repletion must have labs drawn at least 48 hours prior to infusion if transfusion parameters apply.
  - Sodium phosphate 15-30 mmol infuses over 4 hours. Sodium phosphate 40 mmol infuses over 6 hours.
- **LABS**: PHOSPHORUS, PLASMA, Normal, Clinic Collect, PRN if labs not drawn or resulted in 7 days.
- **TREATMENT PARAMETERS**: Fixed dosing with treatment parameters required as specified:
  - Transfusion parameters: **For plasma phosphate level less than mg/dL (within 7 days)**; administer sodium phosphate IV.

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- If labs are not available within specified timeframe, RN to release phosphorus lab.

- **MEDICATION**: Sodium Phosphate, intravenous, ONCE, Administer over 4-8 hours

Dose (must check one):	**Interval (must check one):**
❑ 15 mmol	❑ ONCE
❑ 30 mmol	❑ Repeat every _____ days for _____ doses
❑ 40 mmol	❑ Repeat every _____weeks for x _____ doses
	❑ Other: _____

PRN MEDICATIONS:

- ondansetron ODT (ZOFRAN ODT) tablet, 8 mg, oral, ONCE AS NEEDED for nausea/vomiting (first line),
- ondansetron (ZOFRAN) injection, 4 mg, intravenous, ONCE AS NEEDED for nausea/vomiting, if unable to take oral form of medication, Administer over at least 30 seconds, preferably over 2-5 minutes.

☐ prochlorperazine (COMPAZINE) tablet, 10 mg, oral, EVERY 6 HOURS AS NEEDED, for nausea/vomiting (second line)

☐ prochlorperazine (COMPAZINE) injection, 10 mg, intravenous, EVERY 6 HOURS AS NEEDED, for nausea/vomiting (second line), if unable to take oral form of medication

☐ famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED 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, Tuality 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, 0.5 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

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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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Infusion orders located at: www.ohsuknight.com/infusionorders