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

PO9031

ADULT AMBULATORY INFUSION ORDER

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

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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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756