Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 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:

- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

MEDICATIONS:

<u>Standard Electrolyte Repletion:</u>

- ☐ Calcium gluconate 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min
- ☐ Calcium gluconate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 20-40 min

- ☐ Magnesium sulfate 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 30 min
- ☐ Magnesium sulfate 2 gram in sodium chloride 0.9% 50 mL IV, ONCE over 1 hour
- ☐ Magnesium sulfate 4 gram in sodium chloride 0.9% 100 mL IV, ONCE over 2 hours

Potassium Chloride

- ☐ 20 mEq IV via CENTRAL LINE over 2 hours, in sodium chloride 0.9% 100 mL
- ☐ 20 mEq IV via PERIPHERAL LINE over 2 hours, in sodium chloride 0.9% 250 mL
- ☐ 40 mEq IV via CENTRAL LINE over 4 hours, in sodium chloride 0.9% 250 mL
- ☐ 40 mEq IV via PERIPHERAL LINE over 4 hours, in sodium chloride 0.9% 500 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: _____

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Custom IV Fluid

Base: ***(must check one)***

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

Additives:

- ☐ Calcium gluconate: _____ mg
- ☐ Magnesium sulfate: _____ mg
- ☐ Potassium acetate: _____ mEq
- ☐ Potassium chloride: _____ mEq
- ☐ Potassium phosphate: _____ mMol
- ☐ Sodium acetate: _____ mEq
- ☐ Sodium bicarbonate 8.4%: _____ mEq
- ☐ Sodium phosphate: _____ mMol

Other (Micronutrients):

- ☐ Thiamine 100 mg IV over 1 hour
- ☐ Multivitamin (adult, with vitamin K) 10 mL IV over 2 hours
- ☐ Folic Acid 1 mg IV over 1 hour
- ☐ Folic Acid 1 mg and thiamine 100 mg IV over 1 hour
- ☐ Folic Acid 1 mg, thiamine 100 mg, and Multivitamin (adult, with vitamin K) 10 mL IV over 2 hours

Total volume: ***(must check one)***

- ☐ 1000 mL
- ☐ _____ mL

Rate: ***(must check one)***

- ☐ 50 mL/hr
- ☐ 75 mL/hr
- ☐ 100 mL/hr
- ☐ 125 mL/hr
- ☐ 250 mL/hr
- ☐ 500 mL/hr
- ☐ 1,000 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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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:** _____

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

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

☐ **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