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

PO9031

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
- ☐ Labs already drawn. Date: ________

MEDICATIONS:

Standard Electrolyte Replacement:

- ☐ 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)

- ☐ ONCE
- ☐ Every visit x __________ doses
- ☐ Repeat every _________ days for x _________ doses
- ☐ Repeat every _________ weeks for x ________ doses
- ☐ Other: ____________________________

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Custom IV Fluid

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

- ☐ Dextrose 5%
- ☐ Dextrose 5%-sodium chloride 0.45%
- ☐ Dextrose 5%- sodium chloride 0.9%
- ☐ Sodium chloride 0.45%
- ☐ 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)***

- ☐ ONCE
- ☐ Every visit x _____ doses
- ☐ Repeat every ____ days for x _________ doses
- ☐ Repeat every ____ weeks for x ________ doses
- ☐ Other: __________________________________

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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 # __________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; 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