



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

PO9031



ADULT AMBULATORY INFUSION ORDER

**Hydration for  
Hyperemesis Gravidarum**

Page 1 of 4

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 – Notify provider if urine ketones are greater than trace (**> 5 mg/dL**) or orthostatic blood pressure changes are greater than 20 mmHg after 3 liters of IV hydration.



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**MEDICATIONS:**

**Bag 1**

**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%)

**Additives:**

- Folic acid 1 mg
- 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
- \_\_\_\_\_ mL

**Rate: (must check one)**

- 250 mL/hr
- 500 mL/hr
- 1000 mL/hr
- \_\_\_\_\_ mL/hr

**Interval: (must check one)**

- ONCE
- Every visit
- Repeat every \_\_\_\_ days for x \_\_\_\_\_ doses
- Repeat every \_\_\_\_ weeks for x \_\_\_\_\_ doses
- Other: \_\_\_\_\_

**Bag 2: (additional hydration)**

**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)**

- Every visit with bag 1
- Other: \_\_\_\_\_



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**AS NEEDED MEDICATIONS:**

**Antiemetics (specify 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> line for each PRN medication)**

- ondansetron (ZOFTRAN) 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<sub>2</sub>) 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

**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