**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