



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.



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

ADULT AMBULATORY INFUSION ORDER
**Hydration for
Hyperemesis Gravidarum**

Page 2 of 4

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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)

Rate: (must check one)

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> 250 mL | <input type="checkbox"/> 250 mL/hr |
| <input type="checkbox"/> 500 mL | <input type="checkbox"/> 500 mL/hr |
| <input type="checkbox"/> 1000 mL | <input type="checkbox"/> 1000 mL/hr |
| <input type="checkbox"/> _____ mL | <input type="checkbox"/> _____ 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: _____

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)

Rate: (must check one)

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> 250 mL | <input type="checkbox"/> 250 mL/hr |
| <input type="checkbox"/> 500 mL | <input type="checkbox"/> 500 mL/hr |
| <input type="checkbox"/> 1000 mL | <input type="checkbox"/> 1000 mL/hr |
| <input type="checkbox"/> _____ mL | <input type="checkbox"/> _____ mL/hr |

Interval: (must check one; note PRN orders must include PRN indication)

- Every visit with bag 1
- Other: _____



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

ADULT AMBULATORY INFUSION ORDER
**Hydration for
Hyperemesis Gravidarum**

Page 3 of 4

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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 (H₂) 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:** _____



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

ADULT AMBULATORY INFUSION ORDER

**Hydration for
Hyperemesis Gravidarum**

Page 4 of 4

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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