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; note PRN orders must include PRN indication)**

- ☐ ONCE
- ☐ Repeat every _________ days for x _________ doses
- ☐ Repeat every _________ weeks for x ________ doses
- ☐ Other: ________________________________

## 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; note PRN orders must include PRN indication)***

- ☐ ONCE
- ☐ Repeat every ____ days for x _________ doses
- ☐ Repeat every ____ weeks for x ________ doses
- ☐ Other: _________________________________

**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 # _________________ (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