St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Hydration	Patient Name: Date of Birth: *Patient Identification*

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

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

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.

NURSING ORDERS:

1. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and PRN.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

LABS:

☐ CMP, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
☐ CBC with differential, Routine, ONCE, every (visit)(days)(weeks)(months) – **Circle One**
☐ _____

MEDICATIONS:

Hydration orders

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: _____

Other medications to be administered with hydration (requires dose, route, and frequency):
☐ Thiamine _____
☐ Folic acid _____
☐ Ondansetron _____
☐ _____
☐ _____

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

INFUSION MONITORING/REACTION:
Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.
1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

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☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed