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:

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; 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)***

- ☐ 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)***

- ☐ Every visit with bag 1
- ☐ 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:** _____

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