Spectrum Health

Physician's Orders
HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Once
- ☐ Interval: Every _____ days

Duration:
- ☐ Once
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Ordering Guidelines

☑ ONC PROVIDER REMINDER 4
When ordering hydration orders for outpatient infusion DO NOT CHANGE the MEDICATION FREQUENCY field to anything other than Continuous, ONCE or PRN. The MEDICATION FREQUENCY is how the patient will receive that medication during the visit.

If you would like the patient to come in on a schedule FOR REPEATED TREATEMENT, you should update the INTERVAL in the Therapy plan.

Nursing Orders

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

Hydration - Intermittent infusion/Bolus

☐ sodium chloride 0.9% bolus injection 1,000 mL
1,000 mL, Intravenous, for 60 Minutes, Once, Starting S, For 1 Doses
Outpatient infusion. Maximum infusion rate 999 mL/hr. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML)

☐ lactated ringers IV Bolus 1,000 mL
1,000 mL, Intravenous, for 60 Minutes, Once, Starting S, For 1 Doses
Outpatient infusion. Maximum infusion rate 999 mL/hr. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML)

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NOTE: ***Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.***

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Hydration - Intermittent infusion/Bolus (continued)

☐ custom IVPB builder for fluids less than 1,000 mL

Intravenous, Once, Starting S, For 1 Doses

- ☐ Dextrose 5% _____mL
- ☐ Sodium Chloride 0.9% _____mL

Additives

- ☐ Potassium Chloride _____mEq
- ☐ Sodium Chloride _____mEq
- ☐ Calcium Gluconate _____grams
- ☐ Magnesium Sulfate _____grams
- ☐ _____

Duration

- ☐ 15 minutes
- ☐ 30 minutes
- ☐ 45 minutes
- ☐ 60 minutes
- ☐ ___minutes

Outpatient infusion. Maximum infusion rate 999 mL/hr. If using the Custom IV builder - you should always select an additive and base. Do not use to order a plain hydration fluid. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML)

Hydration - Continuous/Maintenance

☐ sodium chloride 0.9% (NS) infusion

_____ ml/hr, Intravenous, Continuous, Starting S

Outpatient infusion. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

☐ lactated ringers infusion

_____ ml/hr, Intravenous, Continuous, Starting S

Outpatient infusion. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

☐ custom IV infusion builder for fluids more than 1,000 mL

_____mL/hr, Intravenous, Continuous, Starting S

- ☐ Dextrose 5% _____mL
- ☐ Dextrose 10% _____mL
- ☐ Dextrose 5% and sodium chloride 0.2% _____mL
- ☐ Dextrose 5% and sodium chloride 0.45% _____mL
- ☐ Dextrose 5% and sodium chloride 0.9% _____mL
- ☐ Sodium Chloride 0.9% _____mL
- ☐ Sodium Chloride 0.45% _____mL
- ☐ Dextrose 5% and lactated ringers _____mL
- ☐ Lactated Ringers _____mL

Additives

- ☐ Potassium Chloride _____mEq
- ☐ Sodium Chloride _____mEq
- ☐ Calcium Gluconate _____grams
- ☐ Magnesium Sulfate _____grams
- ☐ _____

Outpatient Infusion. If using the Custom IV builder - you should always select an additive and base. Do not use to order a plain hydration fluid. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

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Antiemetic Therapy

☐ promethazine (PHENERGAN) in dextrose 5% 50 mL IVPB
- ☐ 12.5 mg
- ☐ 25 mg

Intravenous, for 15 Minutes, Once, Starting S, For 1 Doses

☐ ondansetron HCl (ZOFRAN) in sodium chloride 0.9 % 50 mL IVPB
- ☐ 4 mg
- ☐ 8 mg
- ☐ 12 mg
- ☐ 16 mg

Intravenous, for 15 Minutes, Once, Starting S, For 1 Doses

☐ dexamethasone sod phos (DECADRON) injection 8 mg
8 mg, IVP, Once, Starting S, For 1 Doses

Additional Antiemetics

☐ Antiemetic with dose and IV solution:

_____

Medications

☐ thiamine (VITAMIN B1) 100 mg in dextrose 5 % 51 mL IVPB
100 mg, Intravenous, for 30 Minutes, Once, Starting S, For 1 Doses

☐ folic acid 1 mg in dextrose 5 % 100.2 mL IVPB
1 mg, Intravenous, for 30 Minutes, Once, Starting S, For 1 Doses
1 mg/mL = 1,667 mcg DFE/mL (Dietary Folate Equivalents)

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:		
TIME	DATE	TIME	DATE	TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 07/16/20

