Providence **ADULT AMBULATORY INFUSION ORDER** **10/2026** **Hydration and Electrolytes Infusion**	**Patient Information** **LEGAL FIRST & LAST NAME:** **BIRTHDATE:**

NOTICE: CHANGE IN HYDRATION & ELECTROLYTES AVAILABILITY
Effective October, 2026

Providence Outpatient Infusion has new practice changes for hydration & electrolyte orders.

*These changes **do NOT apply to pregnant patients;** please return to the website for Hydration for pregnant patient order form.*

Providence Outpatient Infusion (OPI) is only able to accept short term orders for Hydration and/or Electrolytes. This will allow patients who require immediate and short-term Hydration and/or Electrolyte needs to receive treatment at Providence OPI, while allowing time for ordering provider to evaluate treatment and explore alternative treatment locations for ongoing therapy, if needed.

Please ensure your patient is aware of the limited availability for hydration and/or electrolytes at Providence OPI. When appropriate, patients will be notified of the need to transition to an alternative site of care, such as a non-hospital-based infusion center or through home infusion services.

Below is a list of community and home infusion centers that may be able to support your patients' ongoing need for hydration services. Please explore these options with your patient after verifying their insurance coverage.

Emerging Health Ph: 971.290.2010	Metro Ph: 877.448.3627	Providence Home Infusion Pdx Ph: 503.215.4633 Medford Ph: 541.7325566
Medix Ph: 833.696.3349	Option Care @ Legacy Ph: 866.347.8660	Vital Care Ph: 971.484.4940

Thank you for your understanding and cooperation.

Sincerely,

Providence Outpatient Infusion Intake Team

Providence **ADULT AMBULATORY INFUSION ORDER** **10/2026** **Hydration and Electrolytes Infusion**	**Patient Information** **LEGAL FIRST & LAST NAME:** **BIRTHDATE:**

Patient's legal first & last name and date of birth must be on EACH page of this order form (see above header). This form will be returned if any left blank. Complete boxes in grid below.

Provider name & phone #:	Weight & Height: **_____ kg & _____ cm**	Allergies:
Diagnosis code:	Date when pt should start treatment:	Pt's insurance (attach copy of card):

If patient has not scheduled within 90 days of treatment due date, clinic will be notified and referral closed.

1) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the **past 12 months.**
2) Send a copy of related lab results if not available for review in Epic.

Pregnancy screening information:

Per policy, and if applicable to the ordered drug, female patients of childbearing potential may be screened and tested for pregnancy prior to treatment.

ATTENTION!! Please review before proceeding:

- If patient is pregnant, please return to website & use the Hydration form for pregnant patients instead.
- If patient has a diagnosis of POTS (Postural Orthostatic Tachycardia Syndrome), please return to website & consider using the POTS diagnosis Hydration form instead.

Hydration and/or Electrolytes:

FREQUENCY & LENGTH of treatment: ***(must select one)***

- ✓ **1 visit per week.**
- ❑ This is a ONE TIME order only.
- ❑ Short term order valid for **8 weeks of treatment.**
- ❑ Short term order valid for **____ weeks of treatment.**
- ❑ Standing order valid for 1 year from the provider's signature date. I acknowledge patient may be asked to transfer to another facility if long term treatment is needed and I am responsible for coordinating my patient's care.

If short term orders selected above: *Once the first treatment is given, the duration of treatment begins regardless of whether the patient schedules consistently or not during that window of time. If further treatment is needed beyond amount of weeks ordered, the provider is responsible for coordinating continuation of care for the patient at another facility or sending in new orders to continue treatment while arranging alternative site of care.*

HYDRATION:

- ❑ Sodium Chloride 0.9% (NS) infusion. 1 liter per visit.
- ❑ Lactated Ringers infusion. 1 liter per visit.
- ❑ Dextrose 5% and Sodium Chloride 0.45% (D5 ½ NS) infusion. 1 liter per visit.
- ❑ Sodium chloride 0.9% (NS) 1,000 mL with adult multivitamin 10 mL, thiamine (VITAMIN B-1) 100 mg, folic acid 1 mg infusion. 1 liter per visit.

HYDRATION INFUSION RATE: ***(If ordering hydration above, must select one)***

- ❑ Infuse over 2 hours; at 500 ml/hr.
- ❑ Infuse over 1 hour; at 1000 ml/hr.

Providence **ADULT AMBULATORY INFUSION ORDER** **10/2026** **Hydration and Electrolytes Infusion**	**Patient Information** **LEGAL FIRST & LAST NAME:** **BIRTHDATE:**

PRE-MEDICATIONS: ***(optional)***

- ❑ Ondansetron (Zofran) injection, 4 mg IV, every 6 hours, prn nausea or vomiting. May repeat x1 after 30 minutes if no relief.
- ❑ Other: _____.

AS NEEDED MEDICATIONS: ***(optional)***

- ❑ Other: _____, When to give:_____.

ELECTROLYTE REPLACEMENT & ASSOCIATED LABS: ***(select all that apply)***

- ❑ Magnesium sulfate **2 g**/50 ml IVPB, ONCE PRN, over 30 minutes (rapid infusion),
  For Magnesium less than 1.8. Includes lab: Magnesium, STAT, every visit.
- ❑ Magnesium sulfate **4 g**/50 ml IVPB, ONCE PRN, over 60 minutes (rapid infusion),
  For Magnesium less than _____. Includes lab: Magnesium, STAT, every visit.
  - ❑ *Magnesium rate exception: Check here if patient has NOT tolerated rapid Magnesium infusion previously. Instead, please infuse each gram over _____ minutes.*
- ❑ Potassium Chloride **20** mEq/250 ml IVPB, ONCE PRN, over 2 hours, for Potassium less than 3.4.
  Includes lab: Potassium, STAT, every visit. *If CMP lab preferred instead, see optional lab section below.*
- ❑ Potassium Chloride **40** mEq/500 ml IVPB, ONCE PRN, over 4 hours, for Potassium less than _____.
  Includes lab: Potassium, STAT, every visit. *If CMP lab preferred instead, see optional lab section below.*
  - ❑ *Potassium rate exception: Check here to approve Potassium infusion rate of 20 meq per hour instead of standard 10 meq per hour rate. By approving this, you acknowledge there is no need for cardiac monitoring at this rate.*

Optional LABS: ***(If prn electrolyte replacement selected above, required Potassium & Magnesium labs included)***

- ❑ CMP, STAT, every visit.
- ❑ Other lab: _____ STAT, every _____.

Standard included Nursing Orders:

- ✓ Vital signs per clinic routine.
- ✓ Insert peripheral IV if no IV access.
- ✓ Sodium chloride 0.9% (NS) flush 10 mL, intracatheter, PRN, line care.
- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.
- ✓ May use/access CVC line and give 500 units (5ml) heparin flush injection, PRN central line care per policy.

HYPERSENSITIVITY INFUSION REACTION ORDERS

Anaphylaxis or Severe Reaction Orders:

STOP infusion if: Patient experiences the following anaphylaxis or severe symptoms:
Skin/mucous membrane involvement: hives, generalized itch, flush, swollen lips, tongue or uvula
AND at least one of the following:

1. Respiratory compromise, severe SOB with Sp02 less than 90 or greater than 10% drop from baseline Sp02, wheeze, bronchospasm, stridor, reduced peak expiratory flow or hypoxemia.
2. Reduced BP; hypotension (acute drop in SBP less than 90 or greater than 10% from baseline of 90 or less), hypotonia (collapse), syncope, or incontinence.

OR two or more of the following:

1. Skin/mucus membranes involvement: generalized hives, itch or flush, swollen lips, tongue or uvula.
2. Respiratory compromise, severe SOB with Sp02 less than 90 or greater than 10% drop from baseline Sp02, wheeze, bronchospasm, stridor or hypoxemia.
3. Reduced BP: hypotension, syncope, hypotonia (collapse) or incontinence.
4. Persistent GI symptoms: cramping, abdominal pain, or vomiting.

OR Reduced BP after exposure to known allergen: hypotension (drop in SBP less than 90 or greater than 30% decrease from baseline).

1. Stop infusion of chemotherapy/biotherapy.
2. Stay with patient and have another nurse notify MD/APC of symptoms and initiate anaphylaxis or severe reaction orders.

3. Place patient in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5 inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500 mL. At 500 mL/hr, Intravenous, PRN, For anaphylaxis or severe reaction, run wide open to gravity.
- Check vital signs: For anaphylaxis or severe reaction: monitor vital signs every 2 minutes until patient is stable, then every 5 minutes for 30 minutes, then every 15 minutes until back to baseline or follow institutional guidelines. Patients must be monitored for a minimum of 60 minutes post epinephrine administration prior to discharge home.
- Start oxygen. For anaphylaxis or severe reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, Every 15 min PRN, Bronchospasm or shortness of breath unresponsive to first dose of epinephrine. May repeat up to 3 doses as needed. Shake well.
- Post anaphylaxis care communication: If patient experiences anaphylaxis and continues to experience residual symptoms (ie: hives, itching, or bronchospasm) after adequate response to epinephrine (no longer experiencing anaphylaxis), treat residual symptoms per mild or moderate reaction orders.

Mild or Moderate Reaction Orders:

STOP infusion if: Mild or Moderate reaction (non-anaphylaxis). For symptoms not meeting the definition of anaphylaxis/severe.

1. Stop infusion and maintain IV access with NS line, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Notify MD/APC of symptoms and initiate mild or moderate reaction (non-anaphylaxis) orders.
3. If appropriate, place patient in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

MEDICATIONS:

- DiphenhydrAMINE (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, For mild or moderate reaction (non-anaphylaxis). May repeat x1 dose.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, For mild or moderate reaction (non-anaphylaxis). Give with diphenhydramine if ordered. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Check vital signs: For mild or moderate reaction (non-anaphylaxis): monitor vital signs every 5 minutes until back to baseline, then every 15 minutes until resolution of symptoms or follow institutional guidelines. Perform ongoing assessment for progression of anaphylaxis and treat as anaphylaxis as necessary.
- Sodium chloride 0.9% (NS) infusion 500 mL. At 500 mL/hr, Intravenous, PRN, For mild or moderate reaction (non-anaphylaxis). Run wide open to gravity.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5 mg/ml injection, 125 mg, Intravenous, ONCE PRN, For mild or moderate reaction (non-anaphylaxis) unresponsive to initial rescue medications (and not anaphylaxis). OR residual bronchospasms after adequate response to treatment of anaphylaxis requiring more than 2 doses of epinephrine. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Start oxygen. For mild or moderate reaction (non-anaphylaxis). Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%.
- Resume infusion if: mild or moderate reaction:
    1. Resume infusion when symptoms resolve at rate instructed by MD/APC.
    2. Continue to monitor for signs and symptoms of reaction and monitor vital signs as recommended per the specific age.
    3. Notify MD/APC for signs of recurrent infusion reaction for further instruction.
    Anaphylaxis or severe reaction: Do NOT resume infusion.

Providence **ADULT AMBULATORY INFUSION ORDER** **10/2026** **Hydration and Electrolytes Infusion**	**Patient Information** **LEGAL FIRST & LAST NAME:** **BIRTHDATE:**

By signing below, I acknowledge the following:
I am responsible for the care of this patient who is identified on this form. I hold an active license to practice in Oregon and I am authorized to prescribe the medications/treatments on this form.

Provider license #: _____. Provider's printed name: _____.

Provider's signature: _____ Date: _____.

Please complete the following intake questions.

Mobility status

- ❑ Independent (no mobility devices used)
- ❑ Uses assistive device (walker, cane)
- ❑ Uses a wheelchair, but can transfer with minimal or no assistance
- ❑ Moderate to maximum assistance with mobility, explain: _____
  *Clinic location will reach out if unable to accommodate mobility assistance needs.

Bariatric needs

- ❑ Yes, briefly describe_____
- ❑ No

Transportation concerns

- ❑ Yes, briefly describe_____
- ❑ No

Interpreter Service required

- ❑ Yes, language_____
- ❑ No

<u>Outpatient Infusion Services Intake Team:</u>

Please check the appropriate box for the patient's preferred infusion center location:

☐	**PORTLAND**	Phone-**503-215-6046** Fax-**503-487-3582**
☐	**ST. VINCENT'S**	Phone-**503-216-6300** Fax-**971-802-1815**
☐	**WILLAMETTE FALLS**	Phone-**503-215-6046** Fax-**503-487-3582**
☐	**NEWBERG**	Phone-**503-537-6040** Fax-**503-205-8720**
☐	**MEDFORD**	Phone-**541-732-7000** Fax-**541-732-3939**
☐	**SEASIDE**	Phone-**503-717-7650** Fax-**503-470-3146**
☐	**HOOD RIVER**	Phone-**541-387-6445** Fax-**541-387-6137**