PROVIDENCE Health & Services

ADULT AMBULATORY INFUSION ORDER
9/2025
Hydration and Electrolytes Infusion
For Seaside and Medford ONLY

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg **H**eight: _____cm **A**llergies: _____ **D**iagnosis Code: _____
Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.****

1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be **within the past 12 months.**
3) Send a copy of related lab results if not available for review in Epic.

FREQUENCY: ***(must select one)***
Patients may schedule at their convenience which may include back-to-back days of treatment, unless indicated otherwise below.

- ❑ This is a ONE TIME order only.
- ❑ Standing order for up to ____ time(s) a week **for one year.**
- ❑ Standing order for up to ____ time(s) a week for **____ month(s).**
- ❑ **Optional:** Appointments must be scheduled with at least 1 day in between treatments.
- ❑ Other: _____.

MEDICATIONS: ***(must select one)***
Hydration Selection: ***If more than one selected, liters will be infused one at a time, not concurrently. A maximum of 2 liters total is allowed.***

- ❑ Sodium Chloride 0.9% (NS) infusion.
  - ☐ Infuse 1 liter each visit.
  - ☐ Infuse 2 liters each visit.
- ❑ Lactated Ringers infusion.
  - ☐ Infuse 1 liter each visit.
  - ☐ Infuse 2 liters each visit.
- ❑ Dextrose 5% and Sodium Chloride 0.45% (D5 ½ NS) infusion.
  - ☐ Infuse 1 liter each visit.
  - ☐ Infuse 2 liters each 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.
  - ✓ Infuse 1 liter each visit.

HYDRATION INFUSION RATE: ***(must select one)***

- ❑ Infuse each liter(s) over 2 hours; at 500 ml/hr.
- ❑ Infuse each liter(s) over 1 hour; at 1000 ml/hr.

LABS: ***(optional unless selecting prn electrolyte replacement below)***

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

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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.
  - ✓ Lab: Magnesium, STAT, every visit.
- ❑ Magnesium sulfate 4 g/100 ml IVPB, ONCE PRN, over 60 minutes (rapid infusion), for Magnesium less than _____.
  - ✓ Lab: Magnesium, STAT, every visit.
- ❑ Potassium Chloride 20 mEq/250 ml IVPB, ONCE PRN, over 2 hours, for Potassium less than 3.4.
  - ✓ Lab: CMP, STAT, every visit.
- ❑ Potassium Chloride 40 mEq/500 ml IVPB, ONCE PRN, over 4 hours, for Potassium less than _____.
  - ✓ Lab: CMP, STAT, every visit.
- ❑ *Special rate exception: Check here to approve 20 meq per hour infusion rate instead of standard 10 meq per hour rate. By approving this, you acknowledge there is no need for cardiac monitoring at this rate.*

STANDARD INCLUDED NURSING ORDERS:

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

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal signs (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients 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:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction.
- DiphenhydrAMINE (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis. 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.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction. For 1 dose. Shake well. Use with spacer.
- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *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%.
- 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 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Run wide open to gravity.

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.

My physician license Number is #_____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

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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

Outpatient Infusion Services Intake Team:

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

▪	**PORTLAND**	See Location Specific order form on Providence OPI Website.
▪	**WILLAMETTE FALLS**	See Location Specific order form on Providence OPI Website.
□	**MEDFORD**	Phone-**541-732-7000** Fax-**541-732-3939**
▪	**HOOD RIVER**	Phone-**541-387-6445** Call for fax #
□	**SEASIDE**	Phone-**503-717-7650** Fax-**503-470-3146**
▪	**NEWBERG**	See Location Specific order form on Providence OPI Website.