## Legacy Day Treatment Unit
**Provider’s Orders**

**Adult Ambulatory Infusion Order**

**HYDRATION FOR HYPEREMESIS GRAVIDARUM**

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

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### Anticipated Start Date: __________  Patient to follow up with provider on date: __________

***This plan will expire after 365 days, unless otherwise specified below***

Orders expire: ________________

Weight: __________kg  Height: __________cm

Allergies: ___________________________________________

Diagnosis: ____________________________

Diagnosis Code: ____________________________ (please include primary and secondary diagnosis codes)

### GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD** and most recent provider chart or progress note.
2. Please specify base fluid, additives, total volume, and rate.

### LABS COMPLETED: ________________

**LABS TO BE DRAWN** (orders must be placed in TVC Epic by ordering provider if TVC provider):

- 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**
  (Note: Ketone testing is not available at the Legacy Day Treatment Unit at TVC)
- Other: __________________________________________

### NURSING ORDERS (TREATMENT PARAMETERS):

1. **TREATMENT PARAMETER** – Notify provider if urine ketones are greater than trace or orthostatic blood pressure changes are greater than 20 mmHg after 3 liters of IV hydration.

### 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 over at least 2 hours
- Potassium chloride _______ mEq/L (max dose is 40 mEq in 1 liter), infusion rate is 10 mEq/hr
## Legacy Day Treatment Unit

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**HYDRATION FOR HYPEREMESIS GRATIVARUM**

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### Patient Name: 

**Date of Birth:** 

**Med. Rec. No (TVC MRN Only):** 

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

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### 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
- [ ] 2000 mL/hr
- [ ] ______ mL/hr

### Interval: (must check one)

- [ ] ONCE
- [ ] Every visit
- [ ] 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)

- [ ] Every visit with bag 1
- [ ] Other: __________________________________________

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### AS NEEDED MEDICATIONS:

#### Antiemetics (administered in sequence below unless otherwise specified)

- [ ] ondansetron (ZOFRAN) injection 4 mg, IV, AS NEEDED, x 1 dose for nausea/vomiting, give first
- [ ] prochlorperazine (COMPAZINE) injection 5 mg, IV, AS NEEDED, x 1 dose for nausea/vomiting, give second
- [ ] metoclopramide (REGLAN) injection 10 mg, IV, AS NEEDED x1 dose for nausea/vomiting, give third

Alternative sequence of administration: __________________________________________

#### Histamine (H₂) blockers

- [ ] famotidine (PEPCID) 20 mg, IV, AS NEEDED x 1 dose for heartburn/indigestion
Adult Ambulatory Infusion Order
HYDRATION FOR
HYPEREMESIS GRAVIDARUM

Patient Name: ____________________________
Date of Birth: ____________________________
Med. Rec. No (TVC MRN Only): ______________

All orders must be marked in ink with a checkmark (✓) to be active.

Please check the appropriate box for the patient’s preferred clinic location:

☐ Legacy Day Treatment Unit –
The Vancouver Clinic Building
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ Legacy Emanuel Day Treatment Unit
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ Legacy Salmon Creek Day Treatment Unit
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ Legacy Silverton STEPS Clinic
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ Legacy Woodburn STEPS Clinic
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

Provider signature: ____________________________ Date/Time: ____________________________
Printed Name: ____________________________ Phone: ______________ Fax: ______________
Organization/Department: ____________________________