Dartmouth Health

Alice Peck Day Memorial Hospital
Infusion Medicine

MRN:

NAME:

Two identifiers needed
or
Patient Label

DOB:

Hydration/Electrolytes Orders for Nausea/Vomiting

Please fax the completed Therapy Plan, signed by the provider, along with patient demographics, insurance information, patient summary, and last visit note to 603-442-5195.

Patient's Full Name: _____

Birthdate: _____ Phone Number: _____

Address: _____

ICD10 diagnosis related to this treatment: _____

Requested treatment start date: _____

☐ Referral to Alice Peck Day Memorial Hospital (APD) MEDICAL INFUSION

Nausea and Vomiting

☐ Ondansetron (pf) (Zofran) (2 mg/mL) injection 4 mg, Intravenous, ONCE PRN, starting at treatment start time; Nausea, Vomiting.

☐ Ondansetron ODT (Zofran-ODT) disintegrating tablet 4 mg, Oral, ONCE PRN, starting at treatment start time; Nausea, Vomiting.

☐ Prochlorperazine (Compazine) (5 mg/mL) injection 10 mg, Injection, ONCE PRN, starting at treatment start time; Nausea, Vomiting.

Administer: ☐ Intramuscular ☐ Intravenous

☐ Prochlorperazine (Compazine) tablet 10 mg, Oral, ONCE PRN, starting at treatment start time;, Nausea, Vomiting.

Electrolyte Replacement

☐ Magnesium Sulfate 1 g in dextrose 5% 100 mL infusion, Intravenous, ONCE, 1 dose, starting at treatment start time; administer over 60 minutes. ****Warning: Vesicant/Irritant Medication****

☐ Magnesium Sulfate 2 g in sterile water 50 mL infusion, Intravenous, ONCE, 1 dose, starting at treatment start time; administer over 120 minutes. ****Warning: Vesicant/Irritant Medication****

Electrolyte Replacement

☐ Potassium Chloride 10 mEq in sterile water 100 mL infusion, Intravenous, ONCE, 1 dose, starting at treatment start time; administer over 60 minutes. ****Warning Vesicant/Irritant Medication****

Hydration

☐ Lactated Ringers Infusion _____mL, administer over _____hours, Intravenous, ONCE, 1 dose, starting at treatment start time.

☐ Sodium Chloride 0.45% Infusion _____mL, administer over _____hours, Intravenous, ONCE, 1 dose, starting at treatment start time.

☐ Sodium Chloride 0.9% Infusion _____mL, administer over _____hours, Intravenous, ONCE, 1 dose, starting at treatment start time.

Comments: _____

_____
Provider Name (printed)

_____
Provider Signature

Order Date: _____ Time Order Signed: _____

Clinic name: _____

Office phone number: _____