ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

❑ Allenmore Infusion Center
❑ Auburn Infusion Center
❑ Gig Harbor Infusion Services
❑ Puyallup Infusion Center
❑ DHEC Infusion Center
❑ North Spokane Infusion Center
❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

IV FLUIDS:

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:

❑ _____
❑ _____

ICD -10 Code:

❑ _____
❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P; Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters – Flushing, Dressing Changes and Removal

Document patient medical necessity for IV Fluids (check all that apply):

❑ Clinical evidence of hypercalcemia-corrected serum calcium >11mg/dL
  ☑ Repeat CMP weekly for ongoing assessment
❑ Refractory nausea and vomiting longer than 48 hours caused by highly emetogenic chemotherapy
❑ Tube fed patients with oncology diagnosis unable to maximize fluid intake as directed by RDN
❑ Hypotension SBP≤90 as evidenced by dehydration caused by either medications chemotherapy or disease
  ☑ Nurse may hold IV Fluids if SBP>90 on day of service.
❑ Platinum chemotherapy regimens (cisplatin) for high risk of acute renal failure. (Risk factors include: history of renal impairment and those unable to maintain or maximize oral hydration **after** interventions with RDN)
❑ Patients who are high risk for evidence of tumor lysis by evidence of Uric Acid level greater than 8mg/dL
❑ Patients with evidence of refractory diarrhea great than 48 hours who are symptomatic
❑ GI output or ileostomy patients greater 1L/day
❑ Serum creatinine increased by 0.5g/dL from baseline
  ☑ Repeat BMP weekly for ongoing assessment
❑ Other: _____

❑ Normal Saline 0.9% 1 Liter: Infuse over 1 hour: ❑ once a week or ❑ twice weekly.
❑ Lactated Ringers 1 Liter: Infuse over 1 hour: ❑ once a week or ❑ twice weekly.
❑ D5W-NS 1 Liter: Infuse over 1 hour: ❑ once a week or ❑ twice weekly.
❑ Pharmacy may change IV solution based on current product availability.

Exceptions to the above criteria and frequency will be reviewed on a case by case basis with clinical staff and provider.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
IV FLUIDS

MultiCare

60-0224-6 (Rev. 9/24)