MHS Home/Alternate Site Infusion Services
IV Fluids Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	
Patient Allergies:		

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for IV Fluids Infusion

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

Document patient medical necessity for IV Fluids (check all that apply):
□ Clinical evidence of hypercalcemia-corrected serum calcium > 11 mg/dL (requires weekly CMP 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 for high risk of acute renal failure (risk factors: 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 8 mg/dL
□ Patients with evidence of refractory diarrhea greater than 48 hours who are symptomatic
□ GI output or ileostomy patients greater than 1L/day
□ Serum creatinine increased by 0.5 g/dL from baseline (requires weekly BMP for ongoing assessment)
□ Other: _____

Pre-Medication(s): *Select all that apply*:
□ Ondansetron: 4 mg IV once, prior to infusion
□ Other: _____

IV Fluids: (maximum rate is 800 mL/hour)
□ Normal Saline (NaCl 0.9%) □ Lactated Ringers □ D5W-NS (Dextrose 5% / Normal Saline)
□ Other: _____
□ Pharmacy may change IV solution based on current product availability

Volume and rate to be infused (maximum rate is 800 mL/hour):
□ 1000 mL over 75 minutes at 800 mL/hour □ 2000 mL over 150 minutes at 800 mL/hour
□ Other: _____

Frequency:
□ Once weekly □ Twice weekly □ Other: _____

Additional Medications for vascular access maintenance:
- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification: Name: MRN: DOB:	Pre-printed order – Page 1 of 2 IV Fluids Order Set MultiCare

Skilled Nurse to draw labs as follows:
□ CMP weekly □ BMP weekly
□ Other Lab(s) _____ Frequency: _____

Skilled Nurse Interventions:
- Admit *(first visit)* patient to services for home infusion therapy of IV Fluids.
- Complete Skilled Nurse Visit with each infusion for ongoing home infusion therapy of IV Fluids.
- Obtain vital signs (TPR & B/P) at baseline and at completion of the infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Infuse IV Fluids as prescribed.
- Once infusion complete, flush IV line with sodium chloride 0.9% (NS) as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:
- STOP THE INFUSION.
- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.
- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Infusion Services 253-459-6650 (*phone*) / 253-864-2785 (*fax*)
Phone #: _____ Fax#: _____	

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 2 of 2
Name:	IV Fluids Order Set
MRN:	MultiCare Revised 05/24
DOB:	