INFUSION & WOUND THERAPY
1200 W FAIRVIEW ST
COLFAX, WA 99111-9579

WHITMAN HOSPITAL & MEDICAL CLINICS
www.whmc.org

TELEPHONE: (509) 397-5771
FAX: (509) 397-3282

Whitman Hospital Treatment Plan: Hydration with Electrolytes

Patient Information		**Date:**
Patient Name:		DOB:
Phone Number:		Ordering Provider:
WHMC Primary Provider: Phone:		Address:
□ Special Needs (describe):		Phone: Fax:
Weight (kg):	Height:	
Allergies:		

Diagnosis (description):

ICD-10:	**Medication:**	**Authorization Number:**

FAX MUST INCLUDE: History and Physical/Review Systems/Recent Inpatient Note (Must be current within 6 months of treatment)

LAB ORDERS

☐ CBC with differential, ROUTINE, ONCE, every 16 weeks
☐ CMP, ROUTINE, ONCE, every 16 weeks
Additional Labs: _____ Frequency: _____

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Please select from standard replacement bags or custom IV fluid. If ordering custom fluid, please specify base fluid, additives, total volume, and rate.
3. WHMC is limited to no more than 3 additives per bag

STANDARD ELECTROLYTE REPLACEMENT:

☐ Calcium gluconate 1 gram in sodium chloride 0.9%, IV, ONCE over 20-40 min
☐ Calcium gluconate 2 gram in sodium chloride 0.9%, IV, ONCE over 20-40 min
☐ Magnesium sulfate 1 gram in sodium chloride 0.9%, IV, ONCE over 30 min
☐ Magnesium sulfate 2 gram in sodium chloride 0.9%, IV, ONCE over 1 hour
☐ Magnesium sulfate 4 gram in sodium chloride 0.9%, IV, ONCE over 2 hours
☐ Potassium Chloride 20 mEq IV over 2 hours, in sodium chloride 0.9%
☐ Potassium Chloride 40 mEq IV over 4 hours, in sodium chloride 0.9%

Interval (Must check one)

☐ ONCE
☐ Repeat every _____ days for x_____ doses
☐ Repeat every _____ weeks for x_____doses
☐ Other:_____

CUSTOM IV FLUIDS:

BASE (Must check one)

☐ Dextrose 5%
☐ Dextrose 5%-sodium chloride 0.45%
☐ Dextrose 5%- sodium chloride 0.9%
☐ Sodium chloride 0.45%
☐ Sodium chloride 0.9%
☐ Lactated Ringers

Additives: (***No more than 3 additives TOTAL permitted***)

☐ Calcium Gluconate:_____mg
☐ Magnesium sulfate:_____mg
☐ Potassium Acetate:_____ mEq
☐ Potassium Chloride:_____mEq
☐ Potassium Phosphate:_____mMol
☐ Sodium Acetate:_____mEq
☐ Sodium Bicarbonate:_____mEq
☐ Sodium Phosphate:_____mMol

Total Volume: (Must Check One)

☐ 1000 mL
☐ _____mL

Rate: (Must fill in)

☐ _____**mL/hr**

Other:

☐ Thiamine 100 mg IV in sodium chloride 0.9% 50mL over 1 hour
☐ Multivitamin (adult, with vitamin K) 10 mL in Sodium chloride 0.9% 500mL IV over 2 hours
☐ Folic Acid 1 mg IV in Sodium chloride 0.9% 50mL over 30 minutes
☐ Folic Acid 1 mg and thiamine 100 mg IV in Sodium chloride 0.9% 50mL over 1 hour
☐ Folic Acid 1 mg, thiamine 100 mg, and Multivitamin 10 mL (adult, with vitamin K) in Dextrose 5%-sodium chloride 0.45% 1000 mL over 2 hours (WHMC BANANA BAG)
☐ **OTHER:** _____

Interval (Must check one)

☐ ONCE
☐ Repeat every _____ days for x_____ doses
☐ Repeat every _____ weeks for x_____doses
☐ Other:_____

Line Care: standing orders for Outpatient Nursing Services

☒ Insert peripheral IV (if no IV access)

☒ sodium chloride 0.9% flush 10mL PRN, line care

☒ sodium chloride 0.9% (NS) bolus 250mL over 1 hour PRN

☒ May Use/access CVC line, (for patients with existing central lines)

☐ Other_____

HYPERSENSITIVITY MEDICATIONS:

☒ EPINEPHrine 1mg/mL injection 0.3mg IM Every 5 minutes x3 doses. PRN anaphylaxis

☒ Sodium chloride 0.9% (NS) infusion 500 mL at 500mL/hr PRN moderate reaction or anaphylaxis

☒ Diphenhydramine (BENADRYL) injection 25 mg PRN every 15 minutes x 2 doses for moderate reaction

☒ Methylprednisolone sodium succinate (PF) (solu-MEDROL) 62.5 mg/mL injection 125mg IV x1 PRN for severe reaction delivered over 2 minutes.

☒ Famotidine (PF) (PEPCID) injection 20 mg, Once PRN, moderate reaction or anaphylaxis. Dilute 2mL of famotidine with 8mL of normal saline to a final concentration of 2mg/mL and administer over 2 minutes.

☒ Albuterol 90 mcg/puff inhaler 2 puff, inhalation, once PRN. Severe reaction. Shake well and use spacer.

☒ Start oxygen

For MODERATE Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93% per provider instruction.

For SEVERE Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.

☒ **Nursing to discontinue therapy plan in EMR once infusion regimen (last dose) complete**

Provider Signature: _____ Date/Time: _____

Physician Name (Printed): _____

NPI#_____ ****REQUIRED TO BE A VALID ORDER****

Phone: _____ Fax: _____

Please complete all pages of Therapy Plan. Fax completed Therapy Plan and required documentation.
Please call 509-397-5771 with any questions.
Fax ATTN: Whitman Hospital Infusion Therapy Department Fax number: 509-397-3282

Whitman Hospital Medical Staff ONLY—AUTHORIZING OFFICIAL

Provider Signature: _____ Date/Time: _____

Printed Name: _____