LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

FLUIDS/HYDRATION

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

NURSING/ ACTIVITIES

- Insert peripheral IV **or** access Port-a-cath
- Vital Signs (VS): **Initially**, as indicated by patient condition/drug infusion recommendations, and **post infusion.**

MEDICATIONS

☐ **PORT-A-CATH to be accessed**

☒ **0.9% sodium chloride** flush 20 mL IV **x** 1 dose PRN upon accessing and de-accessing port (Saline before Heparin flush)

******Saline before heparin flush******

☒ **heparin** flush 500 units = 5 mL IV **x** 1 dose PRN upon de-accessing port (Saline before Heparin flush)

0.9% sodium chloride - Normal Saline (NS)

☐ **0.9% sodium chloride** 1000 mL at _____ mL/hour **x** _____ mL

☐ **0.9% sodium chloride** with **20 mEq KCL** (*NaCl 0.9% w/ 20 mEq KCL)* 1000 mL at _____ mL/hour x _____ mL

☐ **0.9% sodium chloride** with **40 mEq KCL (***NaCl 0.9% w/ 40 mEq KCL)* 1000 mL at _____ mL/hour x _____ mL

Lactated Ringers (LR)

☐ **LR** 1000 mL at _____ mL/hour x _____ mL

Dextrose 5% (D5W)

☐ **D5W Lactated Ringers** 1000 mL at _____ mL/hour **x** _____ mL

☐ **D5W 0.9% sodium chloride** 1000 mL at _____ mL/hour **x** _____ mL

☐ **D5W 0.9% sodium chloride** with **20 mEq KCL** 1000 mL at _____ mL/hour **x** _____ mL

☐ **D5W 0.45% sodium chloride** 1000 mL at _____ mL/hour **x** _____ mL

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient label

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Banana Bag

☐ **Banana Bag (multivitamin** 10 mL**/ folic acid** 0.2 mL/1 mg**)** in **0.9% sodium chloride** 1000 mL IVPB at 150 mL/hour **x** 3 days
☒ **thiamine** 100 mg / 100 mL IVPB at 150 mL/hour **x** 3 days

☐ **Banana Bag (multivitamin** 10 mL**/ folic acid** 0.2 mL/1 mg**)** in **LR** 1000 mL IVPB at 150 mL/hour x 3 days
☒ **thiamine** 100 mg/ 100 mL IVPB at 150 mL/hour **x** 3 days

HYPERSENSITIVITY / ALLERGIC REACTION

** *Itching, hives, fever* **

☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
☒ Infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic Reaction
☒ VS Q15 minutes **x** 4 and PRN
☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4 hours PRN Hypersensitivity / Allergic Reaction.
☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

Date _____ Time _____ Provider Signature _____

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