LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

ALBUMIN INFUSION FOR PARACENTESIS

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** _____

INSTRUCTIONS TO PROVIDER:

- ***Please ensure insurance authorization has been initiated.***
- *Lab orders should NOT be included on this form – place orders via usual method.* ***Lab monitoring is the responsibility of the ordering Provider.***
- *This plan will expire* ***after 365 days****, at which time new orders will need to be placed.*

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

TREATMENT PARAMETERS:

☒ For **less than** 5 liters of ascitic fluid removed, do **NOT** give **albumin** 25%.
For 5 liters or more ascitic fluid removed, give **albumin** 25% as described in the order below.

MEDICATIONS:

☒ **albumin solution 25%,** IV, infuse at 100 mL/hour

Dosing - *{Indicate below}* round dose to nearest 6.25 grams increment.
***{MAXIMUM = 50 grams per dose}*:**

☐ Administer 6.25 grams/25 mL for every liter of ascitic fluid removed after 5 liter(s)

Other: _____

Interval *{Check ONE}*

☐ Once
☐ Every visit with each paracentesis

Other: _____

Continued next page ➔

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."

LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

ALBUMIN INFUSION FOR PARACENTESIS

Patient Name _____ **DOB** _____

PRN MEDICATIONS:

Other: _____

HYDRATION / MAINTENANCE TKO:

☐ **0.9% sodium chloride** 25 mL/hour IV **x** 1 PRN flush/hydration/main bag/TKO

LINE CARE MAINTENANCE:

☒ Follow facility policies/procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (Alteplase), and/or dressing changes
☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL intra-catheter **x** 1 PRN de-clotting **x** 2 doses
☒ **heparin, porcine - Preservative Free (PF)** 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care
☒ **0.9% sodium chloride** 10 mL IV flush PRN as needed
☒ If applicable, may remove PICC line at the completion of the course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

☒ If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify the provider immediately.
☒ **0.9% sodium chloride** infusion, 200 mL/hour, IV, continuous PRN hypersensitivity/infusion reaction
☒ **acetaminophen** *(TYLENOL)* tablet 650 mg, PO, Q4HRS PRN hypersensitivity/infusion reaction
☒ Oxygen Therapy, low-flow, nasal cannula at 2 Liters/minute, may wean flow to discontinuation. SpO2 Goal – **greater than/equal to** 92%, PRN hypersensitivity/infusion reaction
☒ **diphenhydramine** *(BENADRYL)* injection 25 mg IV **x** 1 PRN hypersensitivity/infusion reaction ***{Maximum of 3 doses}***
☒ **famotidine** *(PEPCID)* 20 mg IV, **x** 1 PRN hypersensitivity/infusion reaction; IV push over at least 2 minutes
☒ **hydrocortisone** *(SOLU-Medrol)* 125 mg IV **x** 1 PRN hypersensitivity/infusion reaction
☒ **albuterol** *(PROVENTIL)* nebulizer solution 2.5 mg/3 mL, nebulization **x** 1 PRN wheezing, hypersensitivity/infusion reaction
☒ **epinephrine** *(ADRENOLIN)* injection 0.3 mg/0.3 mL IM **x** 1 PRN anaphylaxis, hypersensitivity / infusion reaction

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."