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

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 _____

Lower Umpqua Hospital
Fluids/ Hydration – OP Nursing Orders
60050-004MREV0226

Patient label

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FLUIDS/HYDRATION

Patient Name _____ **DOB** _____

Banana Bag

☐ **Banana Bag (multivitamin** 10 mL**/ thiamine** 100 mg**)** in **0.9% sodium chloride** 1000 mL IVPB at 500 mL/hour **x** 1 dose
  ☒ **folic acid** 0.2 mL/1 mg IVP **x** 1 dose

☐ **Banana Bag (multivitamin** 10 mL**/ thiamine** 100 mg**)** in **LR** 1000 mL IVPB at 500 mL/hour x 1 dose
  ☒ **folic acid** 0.2 mL/1 mg IVP **x** 1 dose

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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