Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
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IV Electrolytes Order Form

Epic Referral: REF115141

Patient Name: ____________________________________ **DOB:** _________________

Address: ____ **Phone:** _________________

ICD-10 Diagnosis:

□ Hypomagnesemia (E83.42) □ Hypokalemia (E87.6) □ Hypocalcemia (E83.51) □ Other: ________

Rx: ***Electrolytes will be infused over appropriate rates based on volume and protocols. Electrolytes will be infused in an appropriate amount of solution based upon product availability and patient specific IV access.***

☐ Potassium Chloride 10 mEq IV over 1 hour ☐ Potassium Chloride 20 mEq IV over 2 hours ☐ Potassium Chloride 30 mEq IV over 3 hours ☐ Potassium Chloride 40 mEq IV over 4 hours ☐ Potassium Chloride 50 mEq IV over 5 hours ☐ Potassium Chloride 60 mEq IV over 6 hours	☐ Calcium Gluconate 1g IV ☐ Calcium Gluconate 2g IV ☐ Calcium Gluconate 3g IV ☐ Calcium Gluconate 4g IV ☐ Calcium Gluconate 5g IV ☐ Calcium Gluconate 6g IV
☐ Potassium Phosphate 10mmol IV over 2 hours ☐ Potassium Phosphate 15mmol IV over 3 hours ☐ Potassium Phosphate 20mmol IV over 4 hours	☐ Magnesium Sulfate 1g IV ☐ Magnesium Sulfate 2g IV ☐ Magnesium Sulfate 3g IV ☐ Magnesium Sulfate 4g IV

Order Frequency: ☐ 1 dose ☐ Weekly ☐ Twice per week ☐ Other:___________

Order Duration: ☐ Once ☐ 1 month ☐ 6 months ☐ 1 year ☐ Other:_________

Labs (include frequency): ____

Hold Parameters (Ex: Hold K infusion if K is > 3.5, must be included on standing orders):

____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: _______________________ **Office Fax Number:** ______________________

Prescriber Signature: ____ **Date:** ___________________