Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

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 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

☐ Potassium Phosphate 10mmol IV over 2 hours
☐ Potassium Phosphate 15mmol IV over 3 hours
☐ Potassium Phosphate 20mmol IV over 4 hours

☐ Calcium Gluconate 1g IV over 1 hour
☐ Calcium Gluconate 2g IV over 2 hours
☐ Calcium Gluconate 3g IV over 3 hours
☐ Calcium Gluconate 4g IV over 4 hours
☐ Calcium Gluconate 5g IV over 5 hours
☐ Calcium Gluconate 6g IV over 6 hours

☐ Magnesium Sulfate 1g IV over 1 hour
☐ Magnesium Sulfate 2g IV over 2 hours
☐ Magnesium Sulfate 3g IV over 3 hours
☐ Magnesium Sulfate 4g IV over 4 hours

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

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

Labs (include frequency): ____

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

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:** ___________________