HOME PARENTERAL NUTRITION (ADULT) PRESCRIBER ORDER FORM

Patient Name:

Address:

Date of Birth:	**Gender:**	**Height:** ☐ in ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Parenteral Nutrition Order and Management

☐ **Option Care Health Nutrition Support Team:** Initiate home PN and advance to goal.

☐ **Physician Managed** *(Complete Sections Below)*

Macronutrients		
Amino Acids:	_____	gm/day
Amino Acid Type:	_____	
Dextrose:	_____	gm/day
Lipids:	_____	gm/day
Lipid Type:	_____	
Lipid Days:	_____	days/week
Total Volume:	_____	mL
Infuse Over:	_____	hour(s)
Taper Up:	_____	hour(s)
Taper Down:	_____	hour(s)
Total Calories:	_____	kcal/day
	_____	kcal/kg

Electrolytes		
Sodium Chloride:	_____	mEq/day
Sodium Acetate:	_____	mEq/day
Sodium Phosphate:	_____	mMol/day
Potassium Chloride:	_____	mEq/day
Potassium Acetate:	_____	mEq/day
Potassium Phosphate:	_____	mMol/day
Magnesium Sulfate:	_____	mEq/day
Calcium Gluconate:		mEq/day

Additives		
Adult Multivitamin (10 mL/day):	_____	mL/day
Other Vitamins:	_____	
Trace Element Solution (1 mL/day):	_____	mL/day
Other Trace Elements:	_____	
Other Additives:		

Dosing Recommendations

Protein (gm/kg/day)	0.8 to 1.5	Sodium	1 to 2 mEq/kg/day
Dextrose (gm/kg/min)	4 to 5	Chloride	As needed to maintain acid-base balance.
Lipids (gm/kg/day)	1	Potassium	1 to 2 mEq/kg/day
Volume (mL/kg/day)	30 to 40	Acetate	As needed to maintain acid-base balance.
		Phosphorus	20 to 40 mMol/day
		Magnesium	8 to 20 mEq/day
		Calcium	10 to 15 mEq/day

Anticipated duration of therapy: ☐ months ☐ weeks

Ancillary Orders

Anaphylaxis Orders

If this is a first dose and patient is at risk of a reaction, would you like an anaphylaxis kit provided?

☐ Yes – with 1st dose ☐ No

IV Flush Orders

☐ PICC and Central Tunneled/Non-Tunneled: 0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.
Heparin ☐ (10 unit/mL) 5 mL *or* ☐ (100 unit/mL) 3 mL post-use.
For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ CBC w/ diff, CMP (BMP + LFTs), magnesium, phosphorus, triglycerides prior to PN initiation, twice weekly until stable, then weekly once stable.

☐ Other: _____

Skilled nurse to assess, teach, and train self-administration of PN to patient and/or caregiver. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

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