Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
477 W. Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____

Weight: _____ Height: _____

Allergies: _____

Intradialytic Parenteral Nutrition (IDPN) Order Form

❑ **Check box to initiate order.**

Please complete this form and fax to (360)933-1197

Diagnoses: _____ ICD-9: _____

Days per week (check which days): _____ ❑Mon ❑Tues ❑Wed ❑Thurs ❑Fri ❑Sat

Duration of Dialysis: _____ hours **Start Date:** _____

Formula Components:

❑ **Weight >70kg**
Amino Acids: 115 gm (460 kCal)
Dextrose:75 gm (255 kCal)
Total Volume = 874 ml
Total Calories = 715 kCal

❑ **Weight 60-70 kg**
Amino Acids: 100 gm (400 kCal)
Dextrose: 65 gm (221 kCal)
Total Volume = 760 ml
Total Calories = 621 kCal

❑ **Weight <60 kg**
Amino Acids: 85 gm (340 kCal)
Dextrose: 55 gm (187 kCal)
Total Volume = 646 ml
Total Calories = 527 kCal

❑ **Custom Formula:**
Amino Acids: _____ gm = _____ kCal (4 kCal/gm) = _____ ml (6.67 ml/gm)
Dextrose: _____ gm = _____ kCal (3.4 kCal/gm) = _____ ml (1.43 ml/gm)
Total Volume = _____ ml
Total Calories = _____ kCal

Lipids (20%): Start week _____ of IDPN therapy
- ❑ 20 gm = 200 kCal (add 100 ml to total volume)
- ❑ 25 gm = 250 kCal (add 125 ml to total volume)
- ❑ 30 gm = 300 kCal (add 150 ml to total volume)
- ❑ _____ gm = _____ kCal (10 kCal/gm) = add _____ ml (5 ml/gm) to total volume

Electrolytes:
- ❑ Sodium: _____ mEq
- ❑ Potassium: _____ mEq
- ❑ Calcium: _____ mEq
- ❑ Magnesium: _____ mEq
- ❑ Phosphate: _____ mEq
- ❑ Acetate: _____ mEq
- ❑ Chloride: _____ mEq

Additional Orders:

❑ Regular Insulin (please complete sliding scale) – to be given subcutaneously:
If blood glucose ____ to ____, give ____ units
If blood glucose ____ to ____, give ____ units
If blood glucose ____ to ____, give ____ units
If blood glucose ____ to ____, give ____ units
If blood glucose ____ to ____, give ____ units
If blood glucose >____, notify physician immediately

❑ Other: _____

Duration of therapy: up to 1 year, unless otherwise specified: _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name

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