Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
134 Prince Ave Suite B
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Hyperemesis Treatment Referral Form

Please fax the following information to **(360) 933-1197** to facilitate a swift and easy referral:

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION: Please fax a copy of front and back of all insurance cards if available.

ORDERS

Height: _____ Weight: _____ Allergies: _____

Diagnosis: ❑ Hyperemesis Gravidarum ICD-10: 021.1
❑ Other: _____ ICD-10: _____

Infusion Orders: **Duration of therapy:** ❑ One year ❑ One infusion ❑ Other: _____

- ❑ **Hydration**:❑ Banana Bag (NS+10ml Multivitamins QD+1mg Folic Acid QD; Thiamine 100mg x1st 3 days)
  ❑ Lactated Ringers ❑ Normal Saline ❑ D5-1/2 NS ❑ Other Fluid: _____
  ❑ Infuse _____ Liter(s) IV every _____ day(s) as needed for dehydration, or ❑_____
- ❑ **Ondansetron:** ❑ 8mg IV every 6-8 hours as needed for nausea, or ❑ _____
- ❑ **Diphenhydramine:** ❑ 25mg IV every 6 hours as needed for nausea, or ❑_____
- ❑ **Metoclopramide:** ❑ 10 mg IV every 6-8 hours as needed for nausea, or ❑_____
- ❑ **Famotidine:** ❑ 20 mg IV every 12 hours as needed for heartburn r/t vomiting, or ❑_____
  - **Or Ranitidine** (based in insurance) ❑ 50 mg IV every 6-8 hours as needed, or ❑_____
- ❑ **Other Medication:**_____

- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.
- ❑ Other: _____

Lab Orders:

❑ CBC w/diff	❑ at baseline, and weekly if duration >2 weeks		❑ every _____
❑ CMP	❑ at baseline, and weekly if duration >2 weeks		❑ every _____
❑ Magnesium, Phosphorus	❑ at baseline, and weekly if duration >2 weeks		❑ every _____
❑ BMP	❑ weekly (if no CMP ordered weekly)		❑ every _____
❑ OB6 Panel (#10901 – yellow, lavender, & pink tubes)		❑ one time	❑ every _____
❑ _____	❑ one time	❑ weekly	❑ every _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name