Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W. Horton Rd
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 (unless otherwise specified)

☐ **Hydration**:

☐ Normal Saline : Infuse ____ Liter(s) IV *Frequency*: ☐ Daily PRN ☐ every ____ day(s) PRN or ☐ one time

☐ Lactated Ringers: Infuse ____ Liter(s) IV *Frequency*: ☐ Daily PRN ☐ every ____ day(s) PRN or ☐ one time

☐ Banana Bag (NS+10ml Multivitamins QD+1mg Folic Acid QD; Thiamine 100mg x1st 3 days)
Infuse _____ Liter(s) IV *Frequency*: ☐ Daily PRN ☐ every ____ day(s) PRN or ☐ one time

☐ **Diphenhydramine:** ☐ 25mg IV every 6 hours as needed for nausea, or ☐ _____

☐ **Metoclopramide:** ☐ 10 mg IV every 6-8 hours as needed for nausea, or ☐ _____

-OR- ☐ **Prochlorperazine** ☐ 10mg IV every 6 hour as needed for nausea or ☐ _____

☐ **Ondansetron:** ☐ 8mg 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 ☐ _____

- 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 as needed.

☐ Other: _____

Lab Orders: If no frequency selected we will assume one time order

☐ 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 _____
☐ OB Panel (#20210 – yellow, lavender, & pink tubes)		☐ every _____
☐ _____	☐ one time ☐ weekly	☐ every _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name