477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: ________________________________________

Date of Birth: _________________________ Weight: ___________

IV Access: __________________________ Height:__________

Allergies: ____________________________________________

# Intradialytic Parenteral Nutrition (IDPN) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

**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** | ❑ **Weight 60-70 kg** | ❑ **Weight <60 kg** |
|---|---|---|
| Amino Acids: 115 gm (460 kCal) | Amino Acids: 100 gm (400 kCal) | Amino Acids: 85 gm (340 kCal) |
| Dextrose:75 gm (255 kCal) | Dextrose: 65 gm (221 kCal) | Dextrose: 55 gm (187 kCal) |
| Total Volume = 874 ml | Total Volume = 760 ml | Total Volume = 646 ml |
| Total Calories = 715 kCal | Total Calories = 621 kCal | 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*

**KEY: ◆ Orders are initiated unless crossed out by provider.** ❑ **Check box to initiate order.**
Form # 324
Updated 1/20/2025 -AF