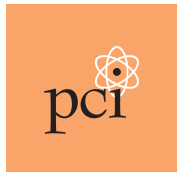


HOME INFUSION



SPECIALTY PHARMACY



NUCLEAR PHARMACY

TPN Order Form

Patient: _____ DOB: _____ Height: _____ Weight: _____

Primary Diagnosis: _____ PN Indication: _____

Access Device: _____ Date TPN to start: _____ Expected Length of Therapy: _____

Insurance Info: Medicare _____ Other _____ ID# _____

Base Solution _____ **Custom** _____ **Standard** (via central access)

Amino Acids (10% Travasol _____ gms/day Or 10% FreAmine or 15%) 50gms/Liter

Dextrose 70% _____ gms/day 150gms/Liter

Lipid Emulsion 20% _____ gms/day 30gms/Liter
Or _____ gms lipid _____ x per week

Additives

Sodium Chloride _____ mEq/day 35mEq/Liter

Sodium Acetate _____ mEq/day

Potassium Chloride _____ mEq/day

Potassium Acetate _____ mEq/day 20mEq/Liter

Sodium Phosphate _____ mEq/day

Potassium Phosphate _____ mEq/day 15mEq/Liter

Calcium Gluconate _____ mEq/day 4.5mEq/Liter

Magnesium Sulfate _____ mEq/day 5mEq/Liter

Multivitamin (MVI-13) _____ ml/day 10ml/day

Multi-trace Elements _____ ml/day Standard

Regular Insulin _____ Units/day

Other _____ /day

Other _____ /day

Other _____ /day

Other _____ /day

Final Volume: _____ ml/day.

_____ Continuous infusion to be infused over 24 hr at _____/hr via pump.

_____ Cyclic infusion to be infused over _____ hr w/ 1 hr taper up and down, via pump.

Infuse daily, dispense every _____ days, and refill _____ times.

Provide parenteral infusion pump [B9004], supply kit [B4222], and administration set [B4224].

Lab Orders:

CMP, CBC, Phosphorus, Magnesium weekly or _____.

Prealbumin, Triglycerides baseline and monthly thereafter, or _____.

Other: _____.

Blood sugar monitoring: (if insulin added to TPN)

_____ Fingertstick Glucose q _____ hr x 3 days, then q _____ hr

_____ Fingertstick BG 2 hrs after TPN starts and 2 hours after infusion DC'd

Activase Protocol: 2mg/2ml, used to restore line patency, as needed.

PICC or Port Maintenance: Normal saline 10ml flush, as needed for line and port care; heparin 10 units/ml for line care; and Heparin 100 units/ml for port care.

Physician: _____ Physician Signature: _____

Date: _____ Office Phone: _____ Office Fax: _____

DEA # _____ Address: _____