COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

OLIVE VIEW-UCLA MEDICAL CENTER

ADULT PARENTERAL NUTRITION (PN) PHYSICIAN ORDERS

Directions: New orders and changes must be faxed to pharmacy **by 1200**. PN administration time is 2000. See Dietary Note in EHR for details of nutrition assessment, including estimation of nutrition needs. **Allergies:** _____

Dx: _____ **Ht:** _____cm **Dosing Wt:** _____kg

PN indication: _____ **Vascular access device:** _____

Base Solution

☐ Standard Central PN		☐ Standard Peripheral PN		Custom PN ☐ Central or ☐ Peripheral	
Dextrose	20%	**Dextrose**	10%	**Dextrose**	_____ %
Amino Acid	4.75%	**Amino Acid**	3%	**Amino Acid**	_____ %
Calories:	870 kcals/L	**Calories:**	460 kcals/L		_____ kcals/L

Additives per day

☐ Adult MVI	10 mL/day	or	_____ mL/day
☐ Trace Elements (Zn, Cu, Mn, Cr)	1 mL/day	or	_____ mL/day
☐ Famotidine [PEPCID]	40 mg/day	or	_____ mg/day
☐ Human Regular Insulin	_____ units/L		

☐ Other:_____

Base Electrolytes per Liter (select one only)

	Na	K	Ca	Mg	Phos	Cl: Acetate
☐ **Standard**	40 mEq/L	40 mEq/L	5 mEq/L	8 mEq/L	10 mM/L	40 : 60
☐ **Renal**	25 mEq/L	20 mEq/L	5 mEq/L	5 mEq/L	0 mM/L	40 : 60
☐ **Custom**	mEq/L	mEq/L	mEq/L	mEq/L	mM/L	:

Infusion (select one only)

☐ **Continuous Infusion Rate:** Start at _____ mL/hr. Advance _____ mL every _____ hours to goal _____ mL/hr

☐ **Cyclic Infusion:** Start @ _____mL x1 hr, Increase to _____ x 1 hr, Increase to _____ x ____hrs,
Decrease to _____ x 1 hr, Decrease to _____ x 1 hr. TPN off x ____hrs

Total volume: _____ mL/day

Lipids (select one only)

Concentration	Volume	Frequency	Rate
☐ 10% (1.1 kCal/mL)	☐ 250 mL	☐ Daily	☐ Infuse at _____ mL/hr over _____ hours
☐ 20% (2 kCal/mL)	☐ 500 mL	☐ Every other day	
	☐ 100 mL	☐ _____	

*****ADDITIONAL ORDERS - PLEASE ENTER THE FOLLOWING INTO THE EHR*****

* Consult to Dietitian (if not already being followed by nutrition services)
* Adjust IVF as needed
* Strict Intake and Output
* POC Blood Glucose (q 4 hr, q 6 hr, or other)
* Weight - daily

Labs: please order now in EHR, then weekly if stable

* Comprehensive Metabolic Panel (daily x 3 days)
* CBC w/ diff
* Hepatic Function Panel (Liver Function Test)
* Prothrombin Time
* Triglycerides (blood)
* APTT - Partial Thromboplastin Time

*** If PN not available or central IV interrupted, notify MD and obtain order to administer D10W at same rate**

*** For more information regarding Nutrition Support, page your floor Dietitian or speak with a Pharmacist**

Provider Name (Print):			
Provider Signature:	ID#:		
Date: / /	Time: :		AM / PM
RN Last Name (Print):			
RN Signature:	Initials:		
Date: / /	Time: :		AM / PM
Clerk/LVN Signature:	Initials:		
Date: / /	Time: :		AM / PM

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ADULT PARENTERAL NUTRITION ORDERS
OV1676 (5-16)