


HOME PARENTERAL NUTRITION (ADULT) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

 option care health	Patient Name: _____		
	Address: _____		
	Date of Birth: _____	Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description: _____	ICD-10 Code: _____
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Parenteral Nutrition Order and Management

Option Care Health Nutrition Support Team: Initiate home PN and advance to goal.

Physician Managed (*Complete Sections Below*)

Macronutrients	Electrolytes
Amino Acids: _____ gm/day Amino Acid Type: _____ Dextrose: _____ gm/day Lipids: _____ gm/day Lipid Type: _____ Lipid Days: _____ days/week Total Volume: _____ mL Infuse Over: _____ hour(s) Taper Up: _____ hour(s) Taper Down: _____ hour(s) Total Calories: _____ kcal/day	Sodium Chloride: _____ mEq/day Sodium Acetate: _____ mEq/day Sodium Phosphate: _____ mMol/day Potassium Chloride: _____ mEq/day Potassium Acetate: _____ mEq/day Potassium Phosphate: _____ mMol/day Magnesium Sulfate: _____ mEq/day Calcium Gluconate: _____ mEq/day
	Additives
	Adult Multivitamin (10 mL/day): _____ mL/day Other Vitamins: _____ Trace Element Solution (1 mL/day): _____ mL/day Other Trace Elements: _____ Other Additives: _____

Dosing Recommendations

Protein (gm/kg/day)	0.8 to 1.5	Sodium	1 to 2 mEq/kg/day
Dextrose (gm/kg/min)	4 to 5	Chloride	As needed to maintain acid-base balance.
Lipids (gm/kg/day)	1	Potassium	1 to 2 mEq/kg/day
Volume (mL/kg/day)	30 to 40	Acetate	As needed to maintain acid-base balance.
		Phosphorus	20 to 40 mMol/day
		Magnesium	8 to 20 mEq/day
		Calcium	10 to 15 mEq/day

Anticipated duration of therapy: months weeks

Ancillary Orders

Anaphylaxis Orders
 If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
 Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

IV Flush Orders

PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.
 Heparin (10 unit/mL) 5 mL *or* (100 unit/mL) 3 mL post-use.
 For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

CBC w/ diff, CMP (BMP + LFTs), mag, phos, triglycerides prior to PN initiation, twice weekly until stable, then weekly once stable.

Other: _____

Skilled nurse to assess, teach, and train self-administration of PN to patient and/or caregiver. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name: _____	Phone: _____	Fax: _____
Address: _____	NPI: _____	
City, State: _____	Zip: _____	Office Contact: _____

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