



Hyperemesis Treatment Referral Form

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 One infusion Other: _____

- Hydration:** Banana Bag (NS+10ml Multivitamins QD+1mg Folic Acid QD; Thiamine 100mg x1st 3days)
 - Lactated Ringers Normal Saline D5-1/2NS Other Fluid: _____
 - Infuse _____ Liter(s) IV every _____ day(s) as needed for dehydration, or _____
- Ondansetron:** 8mg IV every 6-8 hours as needed for nausea, or _____
- Diphenhydramine:** 25mg IV every 6 hours as needed for nausea, or _____
- Metoclopramide:** 10 mg 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 _____
 - Or Ranitidine** (based in insurance) 50 mg IV every 6-8 hours as needed, or _____
- Other Medication:** _____
- ◆ Alteplase 2mg IV to de clot 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%-upto 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 every 72 to 120 hours or as needed.
- Other: _____

Lab Orders:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> CBC w/diff | <input type="checkbox"/> at baseline, and weekly if duration > 2 weeks | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> at baseline, and weekly if duration > 2 weeks | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Magnesium, Phosphorus | <input type="checkbox"/> at baseline, and weekly if duration > 2 weeks | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> BMP | <input type="checkbox"/> weekly (if no CMP ordered weekly) | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> OB6 Panel (#17029 – yellow, lavender, & pink tubes) | <input type="checkbox"/> onetime | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> <input type="checkbox"/> onetime | <input type="checkbox"/> weekly <input type="checkbox"/> every _____ | |

Prescriber Signature

Date

Please Print Name

NPI