SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print, first, last)* _____
DOB: dd / mm / yy . Age: _____ ☐ Female ☐ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Find height & weight in electronic medical record.

Allergies: ☐ **NKA**, or: _____

Pharmacy STAT Barcode

Guide: 1. Where tick boxes are offered, only tick orders that are to be pursued.
2. If completing on hard copy: a) Use BLACK ballpoint. b) Where appropriate, draw a line through orders not needed & initial.
Action Codes: S – scanned to Pharmacy M – transcribed to MAR N – order noted R – request sent ✓ – all orders copied & completed

Parenteral Nutrition Order Set

ACTION CODE

Diagnosis: _____

Indication for Parenteral Nutrition: _____

☐ New order ☐ Order change

Start Date: dd / mm / yy when available from pharmacy

Height _____cm Weight _____kg

Consults

☒ Consult Dietitian via pager

Vitals/Monitoring

Vitals

☒ Weigh at the same time each day on Mon, Wed and Fri

Monitoring

☒ Fluid balance daily

Lab Investigations

Lab Investigations prior to initiation of TPN

☒ CBC ☒ Electrolytes ☒ Urea ☒ Creatinine ☒ Glucose ☒ Calcium
☒ Phosphate ☒ Magnesium ☒ PTT ☒ INR
☒ Liver profile ☒ Triglycerides ☒ Cholesterol

Lab Investigations q Mon and Thurs

☒ CBC ☒ Chem 6 ☒ Urea

Lab Investigations weekly on Thursday

☒ Calcium ☒ Phosphate ☒ Magnesium
☒ PTT ☒ INR ☒ Liver profile

Lab Investigations q Thursday x 2 weeks

☒ Triglycerides ☒ Cholesterol

Glycemic Management

☒ Point of Care Glucose QID x 48 hours, continue until Blood Glucose less than 10 mmol/L for 3 consecutive measurements

Practitioner's Signature: _____ CPSO/RHP# or Printed Name: _____ Date _____ Time _____
Signature (Include Professional Designation) (Print. MDs use CPSO #.) (DD/MM/YY) (24 hrs)

Co-Signature (if applicable): _____ CPSO/RHP# or Printed Name: _____ Date _____ Time _____
Signature (Include Professional Designation) (Print. MDs use CPSO #.) (DD/MM/YY) (24 hrs)

☐ Scanned to Pharmacy

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Parenteral Nutrition Order Set

ACTION CODE

IV Therapy

☒ Change Current IV solution to: _____ at _____ mL/hour
☐ For unplanned TPN stoppage run D10W IV at the same rate as the Amino Acid/Dextrose solution

Parenteral Nutrition

Route of Administration
☐ Central ☐ Peripheral

Amino Acid + Dextrose Solution
☐ Amino Acid 5% + Dextrose 16.6% (Central Use Only)
☐ Amino Acid 5% + Dextrose 10% (Central or Peripheral)

Infusion Rate _____ mL/hour x _____ hours per day from _____ to _____ hrs

Electrolytes

Electrolytes	Electrolyte Content in Amino Acid + Dextrose Solutions (mmol/L)	
	Amino Acid 5%	**Total Required**
Sodium	35	
Potassium	30	
Magnesium	2.5	
Calcium	NIL	
Phosphate	15	
Acetate	75	Per pharmacy
Chloride	35	Per pharmacy
Others:		

Additives
☐ Multi Vitamins for TPN 10 mL daily
☐ Trace Elements 6 concentrate 1 mL daily
☐ Phytonadione 5 mg q Wed

Fat Emulsion (Lipids)
☐ Fat Emulsion 20% at _____ mL/hour x _____ hours per day from _____ to _____ hrs

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Co-Signature (if applicable): _____ CPSO/RHP# or Printed Name: _____ Date _____ Time _____
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