



OUTPATIENT HYDRATION ORDERS:

Name: _____ DOB _____

Height: _____ Weight: _____ (kg) Allergies: _____

Cancer Diagnosis: _____ Diagnosis Code: _____

Other diagnosis: _____ Dehydration (E86.0) _____ Nausea & Vomiting (R11.2)

_____ Assign as Outpatient

√	Medication	Dose	Frequency
	Ondansetron	_____ mg IV	Daily PRN nausea/vomiting
	Promethazine	_____ mg IVPB	Daily PRN nausea/vomiting
	Dexamethasone	_____ mg IV	Daily PRN nausea/vomiting
	IV Bolus: _____ NS _____ D5NS	_____ ml over _____ hours	Daily PRN dehydration and nausea/vomiting
	IV Fluids: _____ NS _____ D5NS	_____ ml/hr for _____ hours	Daily PRN dehydration and nausea/vomiting
	Other: _____ _____	_____	_____

Line Care:

- Normal Saline 10 ml IV flush after each use
- For implanted ports: Heparin 100 units/ml 5 ml flush IV after each use or prior to deaccessing

Physician Signature: _____ Date/Time: _____

