**PHYSICIAN ORDERS**

**Diagnosis**

**Weight**

**Allergies**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

**ORDER DETAILS**

**Patient Care**

**Daily Weight**

- Weigh patient via bed scale at start of procedure and every 24 hours.

**CRRt Treatment Type**

- CVVHD

- ***Recommended Blood Flow Rate is 200-350 mL/min***

**Blood Flow Rate**

- 100 mL/minute
- 200 mL/minute
- 300 mL/minute
- 150 mL/minute
- 250 mL/minute
- 350 mL/minute

**Zero Fluid BALANCE**

**NO Fluid REMOVAL**

- Set ultrafiltration rate to zero.

**Net Hourly Fluid Loss**

**Net Hourly Fluid Gain**

**Non-CRRT Fluid Balance**

- CRRT Fluid Balance: Include All Patient Intake and Output
- CRRT Fluid Balance: Only Vascular Intake and UF Output
- CRRT Fluid Balance: Other

**Communication**

**Notify Provider (Misc)**

- Reason: Significant change in ultrafiltration, bleeding, or change in vital parameter trends.

**Notify Provider (Misc)**

- Reason: Platelet count decreases by more than 50% from baseline AND/OR Hemoglobin dropped by 2gm/dL.

**IV Solutions**

**Dialysate**

**CRRT (Pureflow B 2/3 CRRT 5,000 mL)**

- CRRT, 1,500 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL
- CRRT, 2,000 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL
- CRRT, 2,500 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL
- CRRT, 3,000 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL
- CRRT, 3,500 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL
- CRRT, 4,000 mL/hr
- Pureflow B 2/3 CRRT 5,000 mL

**Order Taken by Signature:** ______________________________________________________________________

**Date** ______________________

**Time** __________________________

**Physician Signature:** __________________________________________________________________________

**Date** ______________________

**Time** __________________________

Continuous Renal Replacement Therapy Plan (CRRT)  Version: 5  Effective on: 01/21/19
CONTINUOUS RENAL REPLACEMENT THERAPY PLAN (CRRT)

PHYSICIAN ORDERS

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<table>
<thead>
<tr>
<th>ORDER</th>
<th>ORDER DETAILS</th>
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| CRRT (Pureflow B 4/2.5 CRRT 5,000 mL) | CRRT, 1,500 mL/hr  
Pureflow B 4/2.5 CRRT 5,000 mL  
CRRT, 2,000 mL/hr  
Pureflow B 4/2.5 CRRT 5,000 mL  
CRRT, 2,500 mL/hr  
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CRRT, 3,500 mL/hr  
Pureflow B 4/2.5 CRRT 5,000 mL  
CRRT, 4,000 mL/hr  
Pureflow B 4/2.5 CRRT 5,000 mL |
| CRRT (Pureflow B 0/3 CRRT 5,000 mL) | CRRT, 1,500 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL  
CRRT, 2,000 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL  
CRRT, 2,500 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL  
CRRT, 3,000 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL  
CRRT, 3,500 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL  
CRRT, 4,000 mL/hr  
Pureflow B 0/3 CRRT 5,000 mL |

Anticoagulation

CRRT Sliding Scale for ACDA and Calcium (CRRT Sliding Scale for ACDA and Calcium Infusion)

***Infuse ACDA via prefilter injection port at 2.5% of HOURLY Blood Flow Rate (Usual Rate: 220 mL/hr)***

Anticoagulant Citrate Dextrose Formula A

CRRT, mL/hr

***Infuse calcium solution via separate central access at 33% of ACDA rate. (Usual Rate: 75 mL/hr)***

calcium chloride 8 g/1000 mL NS

CRRT, mL/hr

8 g, Every Bag

Laboratory

***Blood to be drawn from patient and post filter, NOT dialysis lines***

Regional Citrate Anticoagulation Laboratory (Regional Citrate Anticoagulation Laboratory Guidelines)

***See Reference Text for labs to be placed by Nursing***

CRRT Laboratory Guidelines

***See Reference Text***

Serial Labs

Renal Function Panel

Routine, T,N, q4h

TO

Read Back

Scanned Powerchart

Scanned PharmScan

Order Taken by Signature: ___________________________ Date ___________________________ Time ___________________________

Physician Signature: ___________________________ Date ___________________________ Time ___________________________
<table>
<thead>
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<th>ORDER</th>
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<tbody>
<tr>
<td>Magnesium Level</td>
<td>Routine, T,N, q6h</td>
</tr>
<tr>
<td>Daily Labs</td>
<td>CBC Routine, T,N, Every AM</td>
</tr>
<tr>
<td>Basic Metabolic Panel (BMP)</td>
<td>Routine, T,N, Every AM</td>
</tr>
<tr>
<td>Magnesium Level</td>
<td>Routine, T,N, Every AM</td>
</tr>
<tr>
<td>Phosphorus Level</td>
<td>Routine, T,N, Every AM</td>
</tr>
</tbody>
</table>

Order Taken by Signature: _________________________________________________________________________ Date ______________________ _____ Time ____________________________

Physician Signature: __________________________________________________________________________ Date ____________________________ Time ____________________________

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