UMC Health System

HYPERKALEMIA MULTI PHASE PLAN
- Phase: Medication

Patient Label Here

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	ORDER DETAILS
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Severe Hyperkalemia - Serum Potassium GREATER than 6.5 mMol/L or GREATER than 5.5 mMol/L with EKG changes and/or neuromuscular/cardiac symptoms. **calcium gluconate** ☐ 1,000 mg, IVPush, inj, ONE TIME **Administer PRIOR to D50 and insulin** IV Push over 5 minutes (maximum rate 200 mg/minute)
	glucose (D50) ☐ 25 g, IVPush, syringe, ONE TIME Administer PRIOR to insulin
	insulin regular ☐ 10 units, IVPush, inj, ONE TIME Administer AFTER D50W
	Adjunctive treatment options **albuterol** ☐ 10 mg, inhalation, soln, ONE TIME
	sodium zirconium cyclosilicate ☐ 10 g, PO, liq, ONE TIME
	Mild to Moderate Hyperkalemia - Serum potassium GREATER than 5.5 - 6.5 mMol/L with no acute EKG changes or neuromuscular /cardiac symptoms. **sodium zirconium cyclosilicate** ☐ 10 g, PO, liq, ONE TIME

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

HYPERKALEMIA MULTI PHASE PLAN
- Phase: Patient Care

Patient Label Here

PHYSICIAN ORDERS

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	ORDER DETAILS
	Patient Care
	Hyperkalemia Treatment Algorithm ☐ See reference Text
	Communication
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Obtain Potassium level in ___ hours and POC glucose 30 minutes after medication administration.
	Laboratory
	Potassium Level
	Diagnostic Tests
	EKG-12 Lead
	Respiratory
	Arterial Blood Gas (ABG)

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____