UMC Health System

PARENTERAL NUTRITION PLAN

Patient Label Here

Diagnosis_____ **PHYSICIAN ORDERS**

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
	Patient Care
	Parenteral Nutrition Formula orders will be filled out ON PAPER FORM by Parenteral Nutrition Pharmacist or Physician by 1400 daily. **Daily Weight**
	Strict Intake and Output ☐ Per Unit Standards
	Parenteral Nutrition Administration Guid (Parenteral Nutrition Administration Guidelines)
	POC Blood Sugar Check ☐ q6h 72 hr
	Communication
	Notify Provider (Misc) ☐ Reason: POC Blood Glucose is less than 70 mg/dL.
	IV Solutions
	Parenteral Nutrition Formulation Form ☐ PRINT REFERENCE TEXT FOR PAPER FORM THEN SCAN TO PHARMACY.
	D10W ☐ IV, mL/hr Run at same rate as PN. PRN if PN Solution unavailable. Administer D10W at PN current ordered rate.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	insulin regular (Low Dose Insulin Regular Sliding Scale) ☐ 0-10 units, subcut, inj, q6h, PRN glucose levels - see parameters, x 72 hr Low Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL notify provider. 70-139 mg/dL - 0 units 140-180 mg/dL - 2 units subcut 181-240 mg/dL - 3 units subcut 241-300 mg/dL - 4 units subcut 301-350 mg/dL - 6 units subcut 351-400 mg/dL - 8 units subcut If blood glucose is greater than 400 mg/dL, administer 10 units subcut, notify provider, and repeat POC blood sugar check in 1 hour. Continue to repeat 10 units subcut and POC blood sugar checks every 1 hour until blood glucose is less than 300 mg/dL, then resume normal POC blood sugar check and insulin regular sliding scale.
	Laboratory
	CBC ☐ Routine, T;N, Every M and Th
	Comprehensive Metabolic Panel ☐ Routine, T;N, Every M and Th

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

Order Taken by Signature: _____ Date _____ Time _____

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

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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
	Magnesium Level ☐ Routine, T;N, Every AM
	Phosphorus Level ☐ Routine, T;N, Every M and Th
	Prealbumin ☐ Routine, T;N, Every M and Th
	Triglycerides ☐ Routine, T;N, Every M and Th
	C Reactive protein ☐ Routine, T;N, Every M and Th
	Renal Function Panel ☐ Routine, T;N, Every S/T/W/F/Sa
	Urine 24hr Urea Nitrogen ☐ Routine, T;N, Every Sat
	Respiratory
	Metabolic Cart (Indirect Calorimetry)
	Consults/Referrals
	Consult Pharmacy for TPN

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

Order Taken by Signature: _____ Date _____ Time _____

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