Patient Name: _____ Date of Birth: _____

IV Access: _____ Height: _____ Weight: _____ Allergies: _____

Total Parenteral Nutrition (TPN) Order Form

- Orders are initiated unless crossed out by provider.
- ☐ Check box to initiate order:

Diagnoses: _____ **ICD-10:** _____

Volume/Rate Infusion

☐ Total Volume of _____ml/day

☐ Continuous over 24 hours at _____ml/hour

☐ Cycle over _____hours

_____ml/hr for the first hour, _____ml/hr over the next _____hours, _____ml/hr during the last hour

Base Solution

☐ Central

☐ Dextrose _____gm per BAG

☐ Amino Acids _____gm per BAG

☐ Peripheral (Can be infused through peripheral vein)

☐ Dextrose _____gm per BAG

☐ Amino Acids _____gm per BAG

Lipids 20% ☐ None

☐ 2 in 1 Volume: ☐ 100 ml (20 grams) ☐ 200 ml (50 grams) ☐ 250 ml (50 grams) Frequency: ☐ M W F ☐ Other: _____

Infusion period: 12 hours

☐ 3 in 1 Volume: ☐ 100 ml (20 grams) ☐ 200 ml (50 grams) ☐ 250 ml (50 grams) Frequency: ☐ M W F ☐ Other: _____

☐ Parenteral nutrition **MUST** be administered through a dedicated infusion port and filtered with a 0.22 micron filter for 2 in 1 solutions (dextrose and amino acids only) and 1.2 micron in-line filter for 3 in 1 (dextrose, amino acid and lipid containing solutions)

ALL ADDITIVES ARE PER BAG

Electrolytes

Calcium Gluconate _____mEq (4.65 mEq = 1 gm)

Magnesium Sulfate _____mEq (8 mEq = 1 gm)

Potassium Chloride _____mEq

Potassium Acetate _____mEq

Potassium Phosphate _____mMol (3mM of KPO4 contains 4.4 mEq K)

Sodium Chloride _____mEq

Sodium Acetate _____mEq

Sodium Phosphate _____mMol (3mM of NaPO4 contains 4 mEq Na)

Average Adult Electrolyte Requirements per 24 hours

Sodium 60-150 mEq
Potassium 60-150 mEq
Phosphorous 20-45 mMoles
Magnesium 10-15 mEq
Calcium 10-20 mEq

Caution: To prevent precipitate
{ [2 X Calcium (mEq)] + Phos (mMol)} /
[volume(ml) / 1000] }

OTHER ADDITIVES

☐ Standard Multivitamins (MV1-12 10ml)

☐ Standard Trace Elements (MTE-5 Conc 1ml)

☐ Thiamine 100mg

☐ Folic Acid 100mg

☐ Ascorbic Acid _____mg

☐ L-Carnitine _____mg

☐ Regular Insulin _____Units

☐ Famotidine _____mg

☐ Other _____

☐ Other _____

Prescriber Signature: _____ Date: _____

Prescriber Print Name: _____