FAMILY PHARMACY VITAL CARE
1720 Hillcrest Drive
Vernon, TX 76384
P: 940-552-2999 • F: 940-552-5347

PARENTERAL NUTRITION ORDER FORM

PATIENT INFORMATION

Name: _____ Last, _____ First, _____ Middle			Patient ID Number
Height:	Weight:	Diagnosis:	
Date of Birth:	Date of Order:	Time Order Taken:	
First Infusion Date:	Begin at: ☐ AM ☐ PM	Length of Need:	

BASE SOLUTION

AMINO ACID/PROTEIN (4.0 kcal/g)		Grams of Protein	kcal
Check solution used: ☐ 8.5% ☐ 10% ☐ 15%		Total ML:	
Please specify the AA formulation to be used:			
DEXTROSE/CARBOHYDRATE (3.4 kcal/g)		Grams of Dextrose	kcal
Check solution used: ☐ 30% ☐ 50% ☐ 70%		Total ML:	
CLINIMIX	Product Used:	Total ML:	
LIPIDS (10%: 1.1 kcal/ml; 20% 2 kcal/ml; 30% 3kcal/ml)		Grams of Lipids	kcal
Check solution used: ☐ 10% ☐ 20% ☐ 30%		Total ML:	
Frequency of Lipids: ☐ Daily ☐ Three times per week ☐ Other:			
Please specify the lipid product to be used:			
STERILE WATER FOR INJECTION	☐ Total ML:		
Protein: g/kg/day	Fluid Volume: ml/kg/day	Calories: kcal/kg/day	

ELECTROLYTES

	DOSE/BAG	VIAL CONC	VOLUME/BAG		DOSE/BAG	VIAL CONC	VOLUME/BAG
Sodium Chloride	mEq	mEq/ml	ml	Potassium Chloride	mEq	mEq/ml	ml
Sodium Acetate	mEq	mEq/ml	ml	Potassium Acetate	mEq	mEq/ml	ml
Sodium Phosphate	mM	mM/ml	ml	Potassium Phosphate	mM	mM/ml	ml
Magnesium Sulfate	mEq	mEq/ml	ml	Calcium Gluconate	mEq	mEq/ml	ml
Other:			ml	Other:			ml

VITAMINS/MINERALS/ADDITIVES

Multivitamins	Patient/Caregiver additive	ml	Folic Acid	Patient/Caregiver additive	mg
Multiple Trace Elements		ml	Famotidine	Patient/Caregiver additive	mg
Ascorbic Acid	Patient/Caregiver additive	mg	Other:		
			Other:		
Insulin/Regular	Patient/Caregiver additive	units	Other:		

INFUSION VOLUME AND RATE

Total Volume	ML	Administer over	Hours	
Administration Rate	ML/HR	☐ Continuous	☐ Cyclic	☐ Day ☐ Night
☐ No Taper	☐ Taper up for Hr	☐ Taper down for Hr		
Lab Orders	*Frequency:* ☐ every Monday ☐ every Wednesday ☐ Other:			
☐ CMP ☐ Phos ☐ Magnesium ☐ Calcium ☐ Albumin ☐ Prealbumin ☐ CBC ☐ Other:				

AUTHENTICATION

By signing below it is confirmed that this prescription was written when received, then "read back" to the prescriber for verification of accuracy.	
Pharmacist Signature:	Order Received From (Name):
Physician Signature and Date (where required)	