

Home Parenteral Nutrition (Pediatric) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-805-0513.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Parenteral Nutrition Order and Management

Froedtert Home Infusion Nutrition Support Team: Initiate home parenteral nutrition (PN) and advance to goal.

Physician Managed (complete sections below)

Macronutrients		Electrolytes	
Amino Acids:	<input type="checkbox"/> gm/day <input type="checkbox"/> gm/kg	Sodium Chloride:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Amino Acid Type:	_____	Sodium Acetate:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Dextrose:	<input type="checkbox"/> gm/day <input type="checkbox"/> gm/kg	Sodium Phosphate:	<input type="checkbox"/> mMol/day <input type="checkbox"/> mMol/day
Lipid:	<input type="checkbox"/> gm/day <input type="checkbox"/> gm/kg	Potassium Chloride:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Lipid Type:	_____	Potassium Acetate:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Lipid Days:	_____ days/weeks	Potassium Phosphate:	<input type="checkbox"/> mMol/day <input type="checkbox"/> mMol/day
Total Volume:	_____ mL/kg/day	Magnesium Sulfate:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Infuse Over:	_____ hours/day	Calcium Gluconate:	<input type="checkbox"/> mEq/day <input type="checkbox"/> mEq/day
Taper Up:	_____ hour(s)	Additives	
Taper Down:	_____ hour(s)	Multivitamin:	<input type="checkbox"/> Peds MVI: _____ mL <input type="checkbox"/> Adult MVI: _____ mL
Total Calories	_____ kcal/day	Trace Element Solution (1 mL/day):	_____ mL/day
	_____ kcal/kg	Other Trace Elements:	_____
		Other Additives:	_____

Dosing Recommendations

	Infants	Children	Adolescents		Infants/Children	Adolescents
Protein (gm/kg/day)	2.5 to 3	1.5 to 2.5	0.8 to 2	Sodium	2 to 5 mEq/kg	1 to 2 mEq/kg/day
Dextrose (gm/kg/min)	10 to 14	8 to 10	5 to 6	Chloride	As needed to maintain acid-base balance.	
Lipid (gm/kg/day)	2.5 to 3	2 to 2.5	1 to 2	Potassium	2 to 4 mEq/kg	1 to 2 mEq/kg/day
				Acetate	As needed to maintain acid-base balance.	
				Phosphorous	0.5 to 2 mMol/kg	10 to 40 mMol/day
				Magnesium	0.3 to 0.5 mEq/kg	10 to 30 mEq/day
				Calcium	0.5 to 4 mEq/kg	10 to 20 mEq/day

Anticipated duration of therapy: _____ months weeks

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol

1) TOTAL PARENTERAL NUTRITION (Select One)

10 TO 51 GRAMS OF PROTEIN (B4189)

52 TO 73 GRAMS OF PROTEIN (B4193)

74 TO 100 GRAMS OF PROTEIN (B4197)

OVER 100 GRAMS OF PROTEIN (B4199)

2) TPN TO INCLUDE LIPIDS (B4185)

3) SUPPLY KIT, PER DAY (B4220)

4) ADMINISTRATION KIT, PER DAY (B4224)

5) INFUSION PUMP, PORTABLE (B9004)

6) IV POLE (E0776)

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

CBC w/ diff, CMP (BMP + LFTs), MAG, phosphorous, triglycerides weekly

Other: _____

Skilled nurse to assess, teach, and train self-administration of PN to patient and/or caregiver. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
 N86 W12999 Nightingale Way
 Menomonee Falls, WI 53051