MUNSON HEALTHCARE

Form 12696 6/22/23

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED

Electrolyte replacement every _____ as necessary based on labs. Provider to submit separate order for labs. Labs for electrolyte replacement must be drawn within 96 hours prior to infusion.	Treatment Date:
Order Expiration Date (Required):	Allergies/Reactions (Required):
Diagnosis (Required):	ICD-10 Code (Required):

Lab orders (unless otherwise specified): Provider to submit separate order. Labs for electrolyte replacement must be drawn within 96 hours prior to infusion.

HOLD treatment & notify physician if:	**Emetic Risk:** Minimal **Monitor:** • Vein irritation

MEDICATION	LEVEL	DOSE	ADMINISTRATION INSRUCTIONS	FREQUENCY
☐ **Magnesium sulfate** *(Normal: 1.8-2.5mg/dL)*	**1.5-1.8**	2 grams	In 0.9% NaCl 50 mL IV over 1 hour	x 1 dose
	1.2-1.4	4 grams	In 0.9% NaCl 100 mL IV over 2 hours	x 1 dose
	<1.2	4 grams and pharmacy to notify physician	In 0.9% NaCl 100 mL IV over 2 hours	x 1 dose
☐ **Potassium chloride** *(Normal : 3.4-5 mmol/L)*	**3-3.4**	20 mEq x 3 doses	In 0.9% NaCl 100 mL over 2 hours each, *max: 10 mEq/hr (total 6 hours)*	x 1
	< 3	Pharmacy to notify physician and start 20 mEq x 2 doses daily x 2 days (80 mEq total over 2 days)	In 0.9% NaCl 100 mL over 2 hours each, *max rate: 10 mEq/hr*	x 1

IF PATIENT HAS A HYPERSENSITIVITY REACTION, BEGIN HYPERSENSITIVITY PROTOCOL

ADDITIONAL ORDERS

Reference(s) adapted from Munson Electrolyte Replacement PowerPlan

The provider's full signature(s) is to follow the order

Patient Name: _____

Date of Birth: _____/_____/_____

_____

PROVIDER SIGNATURE **DATE** **TIME**

PRINTED NAME: _____