### APHERESIS / PHOTOPHERESIS

**PHYSICIAN/NP DAILY ORDER SHEET**

**Allergies:**

**Controlled Medications** (circle dose, route, and/or frequency where needed):

- 1 Hydrocodone/APAP [Lortab] 5/325mg PO 1 tab / 2 tabs q4hr prn pain <5 on a 10pt scale
- Oxycodone 5mg / 10mg IR PO every ______ min / 30 min pain 5-10 on a 10pt scale
- Morphine sulfate 1mg / 2mg / 4mg IV every ______ min / 1 mg IV 5-10 on a 10pt scale (dose & freq)
- Hydromorphone [Dilaudid] 2 mg PO / IV every ______ min / 1 mg IV pain 5-10 on a 10pt scale if unable to take morphine (dose & frequency)
- Lorazepam [Ativan] 0.5mg / 1mg for anxiety or vasospasm PO / IV once every 4 hours if needed (dose & route)

**Electrolyte: Potassium (Potassium level)**

Infuse ________ meq potassium chloride IV ONCE. Infuse @ 10 meq/hr.

Give ________ meq of potassium chloride elixir PO ONCE.

Give ________ meq of KIDUR PO ONCE.

**Electrolyte: Magnesium (Magnesium level)**

Infuse ________ gms of magnesium sulfate IV ONCE @ 2 gms/hour.

<table>
<thead>
<tr>
<th>0.9%NS IV fluid orders:</th>
<th>Check one:</th>
<th>RUN at ________ mL/hr</th>
<th>BOLUS over ________ minutes</th>
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<tbody>
<tr>
<td>500ml / 1,000ml (circle volume)</td>
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- Diphenhydramine [Benadryl] 25 mg IV PO ONCE PRN nausae (circle route)
- Loperamide [Imodium] 2 mg tab PO ONCE: PRN diarrhea
- Apply Lidocaine [1-M-X / Ancecream] 4% cream to antecubital area prior to peripheral access. Allow 30 min contact time.
- Ondansetron [Zofran] 8mg PO / IV ONCE: PRN nausae/vomiting (circle route)
- Alleplase [Cathflo] 2 mg/2 ml IV ONCE to each occluded catheter lumen x # of lumens for at least 30min and a max of 2hrs. May repeat if needed x 1. See Vanderbilt Clinical Procedure Cl 30-049.07 for Catheter Clearance by ITPA
- NaCitrte 4% & gentamicin 900 mg/3 ml: Use 1ml to pack each lumen of port x # of lumens ONCE

Other Instructions: If allergic reaction or infusion related reaction occurs, initiate hypersensitivity reaction protocol (CL30-04-10) and CALL MD.

**NP/MD**

Print name ___________________________ Signature ___________________________ Pager # ___________________________ Revised 5/5/2014

Per V/O (RD) ___________________________ Phone/ ___________________________ RN Signature ___________________________ MD Name ___________________________ *Provider must sign orders upon arrival to clinic