# Hyperemesis Treatment Referral Form

**DEMOGRAPHICS**

PatientName: _____ DateofBirth: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

**FINANCIAL INFORMATION**: Please fax a copy of front and back of all insurance cards ifavailable.

**ORDERS** Height: _____ Weight: _____ Allergies: _____

Diagnosis: ☐HyperemesisGravidarum ICD-10:021.1
☐ Other: _____ ICD-10: _____

**InfusionOrders:** **Duration of therapy:** ☐One year ☐One infusion ☐Other: _____

- ☐ **Hydration**:☐Banana Bag (NS+10ml Multivitamins QD+1mg Folic Acid QD; Thiamine 100mg x1st 3days)
  ☐ LactatedRingers ☐NormalSaline ☐D5-1/2NS ☐OtherFluid: _____
  ☐ Infuse _____ Liter(s)IVevery _____ day(s) as needed for dehydration, or☐ _____
- ☐ **Ondansetron:** ☐8mg IV every 6-8 hours as needed for nausea, or☐ _____
- ☐ **Diphenhydramine:** ☐25mg IV every 6 hours as needed for nausea, or☐ _____
- ☐ **Metoclopramide:** ☐10 mg IV every 6-8 hours as needed for nausea, or☐ _____
- ☐ **Famotidine:** ☐20 mg IV every 12 hours as needed for heartburn r/t vomiting, or☐ _____
  - o **Or Ranitidine** (based in insurance) ☐50 mg IV every 6-8 hours as needed, or☐ _____
- ☐ **OtherMedication:** _____

☐ Alteplase2mgIVtodec lotcentralIVaccessperInfusionSolutionsprotocolasneededforocclusion.
☐ FlushlinewithD5W,0.9%NaCl and/orHeparin10units/mlor100units/mlperInfusionSolutionsprotocol.
☐ Lidocaine1% - upto0.2mlintradermallyPRN(maybufferwithsodiumbicarbonate8.4%in10:1ratio).
☐ InfusionReactionManagementperInfusionSolutionsprotocolasneeded.

**Nursing Orders:**

☐ IfnocentralIVaccess,RNtoinsertperipheralIV,rotatesiteevery72to120hoursorasneeded.
☐ Other: _____

**Lab Orders:**

| | | | |
|---|---|---|---|
| ☐ CBCw/diff | ☐ at baseline, and weekly if duration>2weeks | ☐ every | _____ |
| ☐ CMP | ☐ at baseline, and weekly if duration>2weeks | ☐ every | _____ |
| ☐ Magnesium, Phosphorus | ☐ at baseline, and weekly if duration>2weeks | ☐ every | _____ |
| ☐ BMP | ☐ weekly (if no CMPorderedweekly) | ☐ every | _____ |
| ☐ OB6 Panel (#17029 – yellow, lavender, &pinktubes) | ☐ onetime | ☐ every | _____ |
| ☐ ☐ onetime | ☐ weekly | ☐ every | ___ |

_____ _____
*PrescriberSignature* *Date*

_____
*Please Print Name*

NPI