

Parenteral Nutrition (PN) Order Form

Patient Information:
Bayshore Pharmacist Phone: 1-888-313-6988

HCN:	Version Code:	Name:	
Date of Birth:	Address (include Postal Code):		
Phone:			
Patient Weight: kg	Patient Height:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Coordinator Name:		Care Coordinator Phone:	
First Dose: (dd/mm/time)		Deliver: (dd/mm)	
Diagnosis:			
Route: Central (PICC, Port-a-Cath: Size _____, (Hickman, Midline) Hospital Initiation Date: _____			
Frequency: <input type="checkbox"/> Administer daily or <input type="checkbox"/> Other: _____			

**Monday – Friday
0830 – 1630**

Campbellford Memorial Hospital
Fax: 844-631-5800

Haliburton Highlands Health Services
Fax: 844-709-3779

Northumberland Hills Hospital
Fax: 844-631-5801

PN Order: (Each bag will contain the following – note ONE bag/day)			
Amino Acid (e.g. Travasol® without electrolytes) _____ % (Suggested: 5%)	Dextrose _____ % (Suggested: 16.6%)	Bag Volume (amino acids/dextrose) _____ ml	Fat Emulsion to be added _____ % _____ ml (e.g. Intralipid 20%, SMOFLipid 20%, Clinoleic 20%)

Lakeridge Health Bowmanville
Fax: 844-631-5802

Lakeridge Health Oshawa
Fax: 905-444-2516

Note: SMOFLipid 20% requires LU code 525 for ODB coverage in ADULTS, Clinoleic 20% requires LU code 579 **Total Volume (Bag Volume + Fat Emulsion) = _____ mL (Use this volume to calculate Rate)**

****Total Volume Should End In ZERO for Pump Programming****

Rate _____ Total Volume to be infused over _____ hours / day starting at _____ (time)

Electrolytes	Ordered (mmol / day)	Average adult requirement
<input type="checkbox"/> Sodium		80 – 120 mmol / day
<input type="checkbox"/> Potassium		60 – 180 mmol / day
<input type="checkbox"/> Magnesium		5 – 15 mmol / day
<input type="checkbox"/> Calcium		5 – 10 mmol / day
<input type="checkbox"/> Phosphate		20 – 45 mmol / day
<input type="checkbox"/> Chloride	Calculated	
<input type="checkbox"/> Acetate	Calculated	

Trace Elements:
 MTE-6 Conc. ® _____ mL / day
 (standard 1 ml/day)

The following are to be added to the PN The following are to be added to the PN bag before infusion:

- | | |
|--|---|
| <input type="checkbox"/> Daily
<input type="checkbox"/> Multiple Vitamins (Multi – 12) 10 mL (vial 1 + vial 2) daily
<input type="checkbox"/> Pediatric Multiple Vitamins (Mult-12/K1)
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Weekly
<input type="checkbox"/> Vitamin K _____ mg
<input type="checkbox"/> Vitamin K 10mg
<input type="checkbox"/> Other: _____ |
|--|---|

NOTE: Some Additives may require EAP approval and will need to be confirmed (Multi Vitamin & Vitamin K do NOT as of April 30.2019)

Duration of Tx: _____ (days/weeks/months)

Blood Work: CBC (to include Hb + platelets), PT(INR), PTT, Fasting Glucose, Electrolytes, Urea, Creatinine, Total Protein, Albumin, Calcium, Phosphate, Magnesium, Total Bilirubin, Alk Phos, AST, ALT, Cholesterol, Triglycerides, Serum Osmolality

Lakeridge Health Port Perry
Fax: 844-631-5803

Markham Stouffville Uxbridge
Fax: 844-631-5803

Ontario Shores
Fax: 844-631-5803

Peterborough Regional Health Centre
Fax: 855-444-9628

Scarborough Health Network The Scarborough Hospital – Birchmount Site
Fax: 844-631-5804

Scarborough Health Network – General Campus Fax: 844-631-5805

Ross Memorial Hospital
Fax: 844-631-5806

Scarborough Health Network – Centenary Site Fax: 844-631-5808

Lakeridge Health – Ajax/Pickering Fax: 905-444-2524

Whitby Hospital Fax: 905-665-2405

Ordering Physician /Nurse Practitioner Name: _____ Signature: _____ Date: _____	CPSO / CNO#: _____	Contact Information for Ordering Physician Phone: _____ Fax: _____ After Hours: _____ Pager: _____
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