

IV Diuresis Order Set

Phone (616) 394-3547

 = Optional Order = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

Fax (616) 394-2139

ORDERS

Date: _____ Time: _____ Diagnosis Code: (ICD-10) _____

Patient Name: _____ Date of Birth: _____ Weight: _____ (kg)

Allergies: _____

MEDICATIONS

- Furosemide - IV Push.
 20mg 40mg 60mg 80mg 100mg
- Bumetanide - IV Push
 0.5mg 1mg 2mg
- potassium chloride 20mEq oral tablet, extended release
 20mEq 40mEq 60mEq 80mEq
- potassium chloride 20mEq/15mL oral liquid
 20mEq 40mEq 60mEq 80mEq

LABS

- Basic Chemistry Panel, Stat collect. *Unless performed at Holland Hospital <24 hours.*

COMMUNICATION ORDERS

- ATU to call the provider for further instructions if K is LESS THAN or equal to 3.5 or GREATER than or equal to 5, or Cr is GREATER than or equal to 1.8 prior to administering diuretics, unless other parameters specified.
- If other parameters, please specify* _____
- ATU to call the provider if no responses to diuresis within 30 minutes.

Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
 - Diphenhydramine (Benadryl) 25mg slow IVP STAT (may repeat times 1)
 - Acetaminophen (Tylenol) 650mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000mg in 24 hours from all combined sources.)
 - Methylprednisolone (Solu-Medrol) 125mg IVP STAT
- Place O2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____

