EMORY HEALTHCARE

PHYSICIAN'S ORDERS

Therapy: Magnesium Repletion

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ ☐ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m^2): _____

ALLERGIES/Sensitivities: ☐ NKDA or ☐ _____

Start Date (at least 1 wk from today)**:** _____ ☐ **Urgent (Call Infusion Center)**

Treatment Department: ☒ EHW OP Infusion

Appointment Requests: *Tolerance:* ☒ *Use default, for chronic treatments order valid for 1 year*

☐ Infusion Appointment Request - Every _____ days

- ☐ **2 hours** *(if giving 2 g IV): Schedule at most O days before or at most 0 days after*
- ☐ **3 hours** *(if given 4 g IV): Schedule at most O days before or at most 0 days after*
- ☐ ***4 hours*** *(if given 6 g IV): Schedule at most O days before or at most 0 days after*

Labs: *Lab (if selected) will be done as per appointment frequency selected above (unless specified)*

- ☐ Magnesium

Therapy:

Magnesium Sulfate

☐ 2 grams intravenous 50 mL in NS, IV over 1 hour x 1 dose

☐ 4 grams IV intravenous (choose one)
- ☐ 100 mL NS, IV over 2 hours x 1 dose
- ☐ 500mL NS, IV over 2 hours x 1 dose

☐ 6 grams IV intravenous (choose one)
- ☐ 100mL NS, IV over 2 hours x 1 dose
- ☐ 500mL NS, IV over 3 hours x 1 dose

Emergency Medications ☒ *Order will be done as per appointment frequency*

☒ Hypersensitivity reaction protocol
Protocol Document: https://emory.ellucid.com/documents/view/15307/15641

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	