Ontario

Name: _____ BRN: _____

Address: _____

City: _____ PC: _____

Phone: _____ DOB: _____

HCN: _____ VC: _____

Most Responsible Physician: _____

Referral Information
Total Parenteral Nutrition (TPN)

Primary Diagnosis: **Secondary Diagnosis:**

Service Request (where feasible, client/caregiver will be taught treatment protocol) Patient Weight _____

☐ Initial Order ☐ Change in prescription ☐ Latex Allergy (complete as applicable)

☐ Order authorizes up to 6 months of TPN for patient

☐ Clinical Nutrition for TPN Management

☐ TPN Initiation Date _____ (DD/MTH/YYYY)

☐ Central Line maintenance **(Physician or NP to complete Medical orders – Parenteral Therapy WW525)**

☐ In emergencies only, D10W ___ ml/hr x ___ hrs *Completed by: _____

Total Nutrient Admixture (TNA)

	Amino Acid	Dextrose	Na	K	Cl	Acetate	Mg	Phosphate	Ca	Rate
☐ Standard central	5%	15%	35 mmol/L	30 mmol/L	As per pharmacy calculation	As per pharmacy calculation	2.5 mmol/L	15 mmol/L	4.6 mmol/day	__ml/hr for__hrs
☐GRH/SMGH standard central	5%	15%	35 mEq/L	40 mEq/L	As per pharmacy calculation	As per pharmacy calculation	5 mEq/L	13.6 mmol/L	2.3 mmol/L	__ ml/hr for__hrs
☐ Other					As per pharmacy calculation	As per pharmacy calculation				__ ml/hr for__hrs

☐ 20% SMOFLipids (LU 525)

☐ 20% Intralipids ☐ Other _____ Rate: _____ ml/hr for _____ hrs.

☐ MVI –12 10 mL/daily Trace elements Micro+6 conc. 1ml/daily Vitamin K (Phytonadione)200mcg/bag daily

☐ Other _____

Total Rate ____ ml/hr. x ____ hours/day To supply: ____ Kcal and ____ g protein per day

Patient Goals / Tapering Instructions:

☐ Lab requisition complete including requests for:

- ☐ release of results to community Dietitian. Include name of agency and fax numbers
- ☐ lab kit for patient so community Nurse able to draw blood

Blood Work (check 1 box):

☐ **Wellington -** Specify lab: ☐ **Life Labs –** Specify lab:

☐ **CML –** Specify lab: ☐ **Other**

Nurse to:

- ☐ Draw blood every Monday per protocol. (Electrolytes, BUN, Creatinine, blood sugar, AST, ALP, GGT, Ca, PO_4, Mg, CBC, INR/PTT, Total Protein, Albumin)
- ☐ Routine Order effective for course of TPN up to 6 months
- ☐ Other (please specify) _____

Physician Signaure: _____ Registered Dietitian Signature: _____

Print Name: _____ Date: _____ Contact #: _____ Date: _____