

Use electrolyte replacement protocol only if Scr<1.5mg/dL and UOP ≥0.5mL/hr on average over the past 12 hours OR no known acute renal dysfunction + urine void in the past 12 hours.

STANDING **POTASSIUM**
REPLACEMENT ORDER SET:

	<p>For K less than 2.5mmol/L give KCl 80mEq IV and notify primary MD</p> <ul style="list-style-type: none"> patients with central line – maximum rate of 20mEq/hour with continuous EKG monitoring patients with peripheral line – maximum rate of 10mEq/hour
	<p>For K of 2.5 – 2.9mmol/L please give KCl 60 mEq</p> <ul style="list-style-type: none"> <input type="checkbox"/> tablet via PO <input type="checkbox"/> elixir via NG/OGT <input type="checkbox"/> IVPB over 6 hours
	<p>For K of 3.0 – 3.3mmol/L please give KCl 40 mEq</p> <ul style="list-style-type: none"> <input type="checkbox"/> tablet via PO <input type="checkbox"/> elixir via NG/OGT <input type="checkbox"/> IVPB over 4 hours
	<p>For K of 3.4 – 3.9mmol/L please give KCl 20 mEq</p> <ul style="list-style-type: none"> <input type="checkbox"/> tablet via PO <input type="checkbox"/> elixir via NG/OGT <input type="checkbox"/> IVPB over 2 hours
	<p>For K of 4.0-5.1mmol/L no replacement to be given</p>
	<p>For K greater than 5.2mmol/L notify primary MD</p>

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STANDING **PHOSPHORUS**
REPLACEMENT ORDER SET:

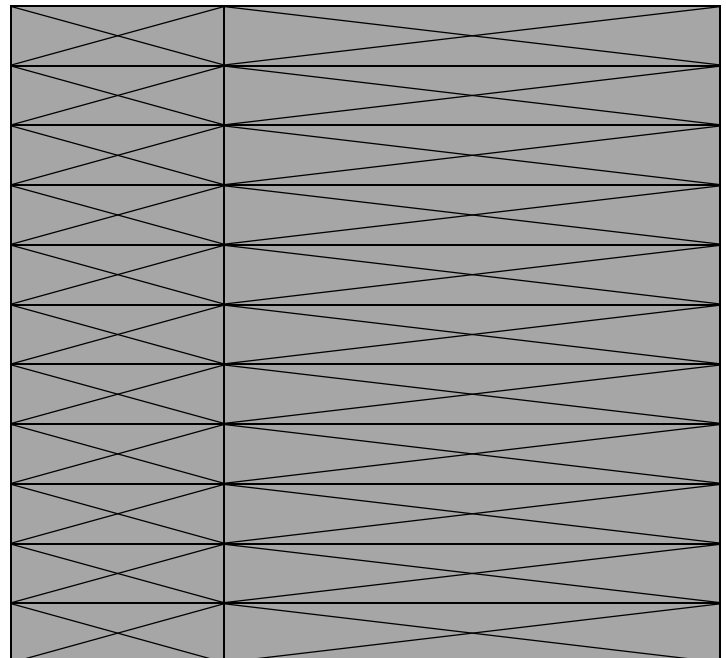
	<p>For phosphorus less than 2mg/dL, please give</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sodium Phosphate 30mmol IVPB over 6 hours <input type="checkbox"/> Potassium Phosphate 30mmol IVPB over 6hours
	<p>For phosphorus less than 2.5mg/dL, please give</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sodium Phosphate 15mmol IVPB over 3 hours <input type="checkbox"/> Potassium Phosphate 15mmol IVPB over 3 hours

STANDING **MAGNESIUM**
REPLACEMENT ORDER SET:

	<p>For Magnesium less than 1.7mg/dL, please give</p> <ul style="list-style-type: none"> <input type="checkbox"/> Magnesium Sulfate 4 grams IV over 3 hours
	<p>For Magnesium of 1.7 – 1.8, please give</p> <ul style="list-style-type: none"> <input type="checkbox"/> Magnesium Sulfate 2 grams over 1 hour

Physician: _____

Date: _____ Time: _____



Electrolytes Replacement Order Set

Guam Memorial Hospital Authority

Revised: 4/10/16 Approved SCC: 3/8/16 MEC: 3/8/16

P&T: 3/11/16 Medicine: 3/11/16 HIMC:4/15/16

Form# CPOE -020

PATIENT ID LABEL

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