Please note this form is fillable, you may choose to fill it out online or print and fill manually.

Please Fax to: 631-319-1924

FocusRx

Physician Order / Total Parenteral Nutrition

Patient Name:				DOB:	
ID:	Telephone #:				
Address:					
Diagnosis:		ICD-10:		HT:	IN:
Diagnosis:		ICD-10:		WT:	KG:
Diagnosis:		ICD-10:		Allergies:	
Diagnosis:		ICD-10:			

Ordering Physician Name:				Physician Phone #:	
Physician Address:				Physician Fax #:	
				Physician NPI:	
Start Date:		Route:		Disp Qty:	Bags:
Duration:	Days:	Frequency:	Days/ Week:	Refills:	Refills:

TPN Formula					
TPN Volume:	ML:	Overfill:	ML	Infusion Time:	Hours:
Amino Acid:	Grams:	AA Brand:		Taper Up:	Hours:
Dextrose:	Grams:	Final Conc:	%	Taper Down:	Hours:
Lipids:	Grams:	Final Conc:	%	Pump:	
Additives Per Bag		**Home Adds Per Bag**		**Ions Per Bag**	
Cal Gluc:	MEQ:	MVI:	ML:	CAL:	MEQ:
Mag Sulfate:	MEQ:	Famotidine:	MG:	MAG:	MEQ:
KOAC:	MEQ:	Reg Insulin:	Units:	NA:	MEQ:
KCL:	MEQ:	Folic Acid:	MG:	K:	MEQ:
KPO4:	MMOL:			CL:	MEQ:
NAOAC:	MEQ:			OAC:	MEQ:
NACL:	MEQ:			PHOS:	MMOL:
NAPO4:	MMOL:	Labs:	CBC / Diff, CMP, CO2, Cal, Mag, Phos,Triglyc, GGT		
MTE- C5:	ML:				
ZN:	MG:	Frequency:			
CU:	MG:	Special Instructions			
MN:					
CR:		B4220 TPN Supplies Per Day			
SE:	MCG:	B4224 TPN Administration Per Day			

****** PROVIDE ALL ADMINISTRATIVE SUPPLIES******					
ACCESS			MAINTENANCE:		
FLUSH:	Normal Saline:	Heparin 100:	Units / ML:	Heparin 10	Units / ML:
Before	ML:		ML:	Drug Frequency:	ML:
After:	ML:		ML:	Dosing Schedule:	ML:
Verbal Order Form:				Date:	Time:
Prescriber Signature:				Date:	Time:
Pharmacist Name:					
Pharmacist Signature:				Date:	Time: