(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____
Allergies with reaction type:_____

D/C HOME WITH CENTRAL LINE AND HOME TPN Version 3 9/15/2010

Diagnosis:_____
_____

Anticipated length of need: _____

TPN Formula: _____ Standard Central
_____ Customized Formula (see attached)

Has pt failed enteral feedings. Y N

If no, Reason enteral feedings cannot be used:
_____
_____
_____

Current Access (Check one) : _____ PICC Line _____Lumen
_____ HICKMAN _____Lumen
_____ OTHER _____

Anticipated length of need: _____

Change Central Line Dressing: Every _____hours or _____times per week

Change caps: _____ times per week.

Flush each lumen of central line with:

_____ 5 ml of Normal Saline prior to initiation of each bag of TPN
_____ 5 ml Heparin Solution daily for routine care if not being used.

Central line supplies: Dispense per month
1. _____Central line site care kits
2. _____Central line caps
3. _____PICC line securement device
4. _____Alcohol Wipes
5. _____Tape Type_____

Initials_____

(place patient label here)
Patient Name:
_____

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PROVIDER ORDERS

6. _____ Tubular dressing

7. _____ 5 ml prefilled 100 unit/ml Heparin syringes (adults)
   _____ 5 ml prefilled 10 unit/ml Heparin syringes (pediatric)

8. _____ 5 ml prefilled Normal Saline Syringes

9. _____ 12 inch extension sets
10. _____ Aquaguard
    _____ Shower gloves

HOME CARE REFERRAL: Y N

F/U TPN administration, central line care, and teaching as indicated.

Provider Signature:_____Date:_____Time:_____