(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:_____

NICU Prostaglandin Infusion

Version 2 9/19/2013

Patient Weight:_____

Medications

- Recommended taper: 0.1 to 0.05 to 0.025 to 0.01 microgram/kilogram per minute. Minimum rate of infusion is 0.01 microgram/kilogram per minute.
  alprostadil (PGE-1) 500 microgram in 50 milliliters Dextrose 5% water (10 microgram/milliliter)
  - ☑ 0.1 microgram/kilogram per minute continuous intravenous infusion
  - ☐ _____ microgram/kilogram per minute continuous intravenous infusion

Provider Signature:_____Date:_____Time:_____