Total Parenteral Nutrition (TPN) Referral Form

Tel: 626-962-1061 ♦ Fax: 626-962-1157

Patient's Information

Patient Name:	**HT:**	**WT:**	**Sex: ___ M ___F**	**Date of Birth:**
Address:		**City:**	**State:**	**Zip Code:**
Phone:		**Allergies:** _____		
Insurance:		**Phone:**		
ID#:		**Group #:**		

☐ Pharmacy to Dose- Labs and H&P attached

Prescription

FORMULA	QUANTITY ADDED (ml)	CONVERSION	CALORIES	GM
DEXTROSE 70%		3.4 CAL/GM		
AMINO ACID 15%		4 CAL/GM		
LIPIDS 20%		10 CAL/GM		
Sterile Water	QS to_____			

☐ Standard Electrolytes

Sodium (Na+) 35 mEq/20ml
Potassium (K+) 20 mEq/20ml
Calcium (Ca++) 4.5 mEq/20ml
Magnesium (Mg++) 5 mEq/20ml
Chloride (Cl^-) 35 mEq/20ml
Acetate (CH_3COO^-) 29.5mEq/20ml

☐ Custom Electrolytes

Sodium Chloride _____ meq/L
Potassium Chloride _____ meq/L
Calcium Gluconate _____ meq/L
Potassium Phosphate _____ mM/L
(3mM Phosphate contains 4.4 meq Potassium)
Magnesium Sulfate _____ meq/L

Sodium Acetate _____ meq/L
Potassium Acetate _____ meq/L
Sodium Phosphate _____ meq/L

Recommended Additives

☐Adult Multivitamins (10 ml daily)* _____ ☐Trace Elements Adult (1 ml daily)* _____
*Multivitamins will be added every day unless otherwise specified.

Additional Additives & Special Instructions

Other:_____

TPN Rate

☐ Rate: _____ ml/hr X _____ Hours

Labs

☐ CMP, Mg, Phos, LFTs & TG-at baseline, within 48 hours of TPN initiation then weekly ☐ Weight Weekly

☐ CBC w/diff- at base line, then weekly

Physician and Diagnosis

Physician's Name:	**Phone:**	**Fax:**
Signature:	**Date:**	**NPI:**
Diagnosis: _____		

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