Patient Name:_____ **Date of Birth:** _____

Address: _____

Phone: _____

ICD-10 Diagnosis: ☐ Hypocalcemia (E83.51) ☐ Other:_____

Rx:
Electrolytes will be infused over appropriate rates based on volume and protocols. Electrolytes will be infused in an appropriate amount of solution based upon product availability and specific IV access.
Labs:
☐ Calcium ionized level ☐ Other:_____
Frequency: ☐ Once ☐ Daily ☐ Weekly ☐ Twice per week ☐ Other:_____

Duration: ☐ Once ☐ 1 Week ☐ 1 Month ☐ 6 Months ☐ 1 Year ☐ Other:_____

Calcium Replacement Protocol (standard concentration: 1 gram/100 mL or 2 grams/100 mL)

Current Serum Ionized Calcium Level	Total Calcium Replacement	Monitoring
1 – 1.1 mMol/L	Calcium Gluconate 1 gram IV over 1 hour	No additional action
0.85 – 0.99 mMol/L	Calcium Gluconate 2 gram IV over 1 hour	Recheck serum calcium ionized level 2 hours after infusion complete
Less than 0.85 mMol/L	Calcium Gluconate 2 gram IV over 1 hour AND contact provider	Recheck serum calcium ionized level 2 hours after infusion complete

**Port/PICC care per protocol will be performed if applicable including Heparin flush (500 units/5 mL) and Cathflo (2 mg) as needed for patients with a port.

Prescriber printed name: _____

Prescriber full address:_____

Office phone number:_____ **Office fax number:**_____

_____ _____ _____
Prescriber signature Date Time

Questions? Call (419) 591-3858. Please fax completed form to (419) 592-4004.