

# Hyperemesis Gravidarum Assessment

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMAIL \_\_\_\_\_ EST DUE DATE \_\_\_\_\_

CARE PROVIDERS			
	Name	Phone	
Perinatologist		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former
Obstetrician		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former
Gastroenterologist		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former
Dietician/Nutritionist		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former
Midwife		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former
		( )	<input type="checkbox"/> Current <input type="checkbox"/> Former

HEALTH HISTORY			
<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Surgery	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid Disease: <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper
<input type="checkbox"/> Cyclic Vomiting Syndrome	<input type="checkbox"/> Migraines	<input type="checkbox"/> Diabetes	<input type="checkbox"/> During pregnancy
<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Stomach/GI Ulcers	<input type="checkbox"/> Bleeding or	<input type="checkbox"/> Clotting Issues
<input type="checkbox"/> PMS or irregular periods	<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Celiac Disease/Food Allergies	
<input type="checkbox"/> Family History of HG	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Due to TPN
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Intolerance of Oral Hormones	
<input type="checkbox"/> Ovarian Cysts/PCOS	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Other:	
<input type="checkbox"/> Molar Pregnancy	<input type="checkbox"/> Seizures		

No previous pregnancy (the remainder of this page and the next 4 sections are pregnancy history which you may skip.)

PREGNANCY & HG SUMMARY			
Total number of pregnancies? _____	How many pregnancies with severe nausea/vomiting or HG? _____		
How many live births? _____	How many pregnancies with multiples? _____		
How many pregnancy losses? _____	# Pregnancies aborted due to HG: _____		
How many ER visits for HG? _____	How many inpatient stays for HG? _____	Est. total days: _____	
Week symptoms usually start: _____	Week symptoms ended: _____	<input type="checkbox"/> @ Delivery	
How many weeks on bed rest? _____	How long did you take medications? _____	weeks or months	

*Hyperemesis Gravidarum (HG) is severe nausea and/or vomiting that causes you to lose weight and need medical treatment such as medications or IV fluids, and results in the inability to do your usual activities and maybe care for yourself.*

PREGNANCY TREATMENT HISTORY							
Preg #	Medication	Dose (e.g. 4 mg)	Pill/IV/Patch SubQ/Rectal	Frequency (3x/day)	During which weeks?	How did it affect you?	Any Problems?

e.g. Zofran (ondansetron), Compazine/Stemetil, Reglan (metaclopramide), Kytril (granisetron), Diclegis/Diclectin, Phenergan (promethazine), Steroids

In a prior pregnancy, did you receive:  IV Nutrition (TPN)  Tube Feedings  Home Health Care  Total Days: \_\_\_\_\_  
 In a prior pregnancy, did you experience:  Depression/anxiety  Delivery complications \_\_\_\_\_  
 Other problems: \_\_\_\_\_

PREGNANCY OUTCOME SUMMARY						
Year of Delivery or Loss	HG Y/N (yes/no)	Weight Loss (e.g. 5 kg)	How Many Weeks Pregnant?	Outcome: Miscarriage (MC) Stillbirth (SB) Termination (Ab) Live Birth (LB)	Complications: e.g. Preeclampsia (PE), Placental Abruption (PA) Premature Delivery (PD)	Child: Health, Genetic, Psychological/Behavioral or Developmental Issues

POSTPARTUM SYMPTOMS & DURATION					
Symptom	# Weeks	Symptom	# Weeks	Symptom	# Weeks
<input type="checkbox"/> Depression/Anxiety		<input type="checkbox"/> Fatigue/weakness		<input type="checkbox"/> Sleep difficulties not due to child(ren)	
<input type="checkbox"/> Traumatic Stress		<input type="checkbox"/> Reflux/GI Issues		<input type="checkbox"/> Dental Issues	
<input type="checkbox"/> Fully Recovered @		<input type="checkbox"/> Other:			

CHILD OUTCOMES						
1st	<input type="checkbox"/> Reflux <input type="checkbox"/> Colic	<input type="checkbox"/> Growth Restriction	<input type="checkbox"/> Developmental/ Behavioral Issues	<input type="checkbox"/> Autoimmune Issues	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Other:
2nd	<input type="checkbox"/> Reflux <input type="checkbox"/> Colic	<input type="checkbox"/> Growth Restriction	<input type="checkbox"/> Developmental/ Behavioral Issues	<input type="checkbox"/> Autoimmune Issues	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Other:
3rd	<input type="checkbox"/> Reflux <input type="checkbox"/> Colic	<input type="checkbox"/> Growth Restriction	<input type="checkbox"/> Developmental/ Behavioral Issues	<input type="checkbox"/> Autoimmune Issues	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Other:
4th	<input type="checkbox"/> Reflux <input type="checkbox"/> Colic	<input type="checkbox"/> Growth Restriction	<input type="checkbox"/> Developmental/ Behavioral Issues	<input type="checkbox"/> Autoimmune Issues	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Other:

# VISIT ASSESSMENT

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WEIGHT: Pre-Preg \_\_\_\_\_ lb/kg    Current \_\_\_\_\_ lb/kg    ALLERGY: \_\_\_\_\_    HELP Score: \_\_\_\_\_  
 Lost this week \_\_\_\_\_    Total Lost \_\_\_\_\_ %    Ketones: \_\_\_\_\_    Previous HELP Score: \_\_\_\_\_

## CURRENT CARE - MEDICATIONS

Medication	Dose (e.g. 4mg)	Frequency (e.g. 3x/day, 1x/week)	Route (Oral/IV)	Do you keep it down?	Effect of medication or problems
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> Y <input type="checkbox"/> N	

Medication side-effects:    Constipation    Anxiety    Drowsiness    Headaches    Dizziness    Dry Mouth  
 Other issues: \_\_\_\_\_

## CURRENT CARE - SUPPLEMENTS & VITAMINS

Supplements (include brand & main ingredient(s) if known)	Dose (e.g. 4 tabs)	Frequency (e.g. 3x/ day, 1x/week)	Reason (e.g. reflux)

Vitamins:    Prenatal    Vit B6    B1    Thiamin    Iron    Other: \_\_\_\_\_

Nutrition:    IV fluids (TPN/TPPN)    NG/NJ/Tube feedings    Start Date \_\_\_\_\_    None

Current IV or nutritional therapy: \_\_\_\_\_

IV/Midline/PICC/G or J-tube Symptoms:    Redness    Swelling    Pain    Warmth    Rash/Infection    Fever/Chills

Additional treatments:    Acupuncture    Other: \_\_\_\_\_

I am considering termination of my pregnancy because I'm sick.    Yes    No    Maybe

## CURRENT NUTRITION

What did you eat yesterday? \_\_\_\_\_

Foods you can eat: \_\_\_\_\_

Foods you cannot eat: \_\_\_\_\_

Amount of food you eat compared to pre-pregnancy: \_\_\_\_\_% (e.g. 50% = half of what you normally eat)

**RATE ANY YOU HAVE EXPERIENCED RECENTLY USING A SEVERITY SCALE OF 0 TO 5**  
*0=OK Now, 1=Mild, 3=Moderate, 5=Severe*

Symptom	Severity	Symptom	Severity	Symptom	Severity
Heartburn/Reflux		Excessive saliva		Vision changes	
Constipation		Diarrhea		Hoarseness	
Jaw pain/clicking		Abdominal pain		Heart rate changes	
Difficulty walking		Abdominal fullness		Confusion	
Breathlessness		Difficulty swallowing		Poor sleep/Insomnia	
Fever or Chills		Depression/anxiety		Headaches/Migraines	
Difficulty with memory or focus		Frequent urination, or burning or pain		Throat burning/bleeding	
Dry skin/lips/mouth		Blood in urine		Difficulty functioning	
Bloody vomit		Bloody or fatty stool		Weakness/Fatigue	
Blood clots		Urine/stool leakage		Muscle cramps/spasms	
Fainting or Dizziness		Vaginal bleeding		Hemorrhoids	
Pain:		Other:			

**SYMPTOM ASSESSMENT**

Main Triggers  Noise  Light  Smells  Motion  Car Rides  Sight of Food  
 Other: \_\_\_\_\_

Week symptoms started: \_\_\_\_\_ Hours of nausea each day: \_\_\_\_\_

How would you rate the overall severity of nausea/vomiting:  Mild  Moderate  Severe  Varies

How many times do you vomit daily: \_\_\_\_\_ How many times do you retch: \_\_\_\_\_  Varies each day

Vomit Description:  Bile  Blood  Liquid  Coffee grounds  Undigested food  Other: \_\_\_\_\_

Appetite:  None  Very little  Sometimes  Painfully hungry  Varies all day  Other: \_\_\_\_\_

Days since last BM: \_\_\_\_\_  None/Minimal  Small  Medium  Large  Describe: \_\_\_\_\_

Symptoms compared to previous pregnancy:  Worse  Better  Same  Unsure  Varies  N/A

**PSYCHOSOCIAL SUMMARY**

Who helps care for you? \_\_\_\_\_

Employment status:  Full-time  Part time  On Leave/Disability  Student  Work @ home  None

Number of adults in your home? \_\_\_\_\_ Number of kids under 18 years? \_\_\_\_\_

What activities are you unable to do? \_\_\_\_\_

What causes the most stress? \_\_\_\_\_

Other concerns? \_\_\_\_\_

# PLAN OF CARE

NAME \_\_\_\_\_ DATE \_\_\_\_\_ GA: \_\_\_\_\_ weeks

Follow-up in \_\_\_ days     Admit Inpatient     Private Room     \_\_\_\_\_

**Consults:**  Home Health     Perinatology/MFM     RD/CN     GI     PT     Psych     Neuro     Other: \_\_\_\_\_

**Diagnostics:** \_\_\_\_\_

Ultrasound:  Abdominal     Vaginal     Pelvic     Other: \_\_\_\_\_

Lab Panels:  Metabolic     Thyroid     Electrolytes     Weekly CMP for TPN     Liver     Renal     H-pylori

Other: \_\_\_\_\_

**Antiemetic Recommendations:**  Give HER Foundation Referral/Brochures

Change: 1. Dose    2. Frequency    3. Route    4. Add (or change) Rx     Check Ketones @ home every \_\_\_ days

Take on strict schedule vs. prn & wean slowly if asymptomatic 14+ days     Do HELP Score @ home every \_\_\_ days

MEDICATIONS & ESSENTIAL VITAMINS			
Medication	Dosage	Route **	Considerations
<input type="checkbox"/> Diclegis/Diclectin <input type="checkbox"/> Unisom <input type="checkbox"/> Diphenhydramine	___ tabs q ___ hours or <input type="checkbox"/> QHS <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> May cause drowsiness. <input type="checkbox"/> Check daily B6 total.
<input type="checkbox"/> Zofran (ondansetron) ≤32mg <input type="checkbox"/> Kytril (granisetron) ≤2mg <input type="checkbox"/> Anzemet (dolasetron) <input type="checkbox"/> Remeron (mirtazapine)	___mg q ___ hours or <input type="checkbox"/> BID <input type="checkbox"/> QID <input type="checkbox"/> PRN _____	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> PR <input type="checkbox"/> ODT vaginally <input type="checkbox"/> Other: _____	<input type="checkbox"/> Take on strict schedule. <input type="checkbox"/> Docusate _____ QHS <input type="checkbox"/> Laxative _____ PRN <input type="checkbox"/> √ LFT & EKG changes.
<input type="checkbox"/> Phenergan ≤25mg QID (promethazine)	___mg q ___ hours or <input type="checkbox"/> QHS <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> PR <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> Use antihistamine to prevent side-effects.
<input type="checkbox"/> Reglan/Maxeran/Primperan (metoclopramide) 5-20mg QID	___mg <input type="checkbox"/> Before meals (30 min) <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> PR <input type="checkbox"/> _____	<input type="checkbox"/> Antihistamine (for side-effects); slow IV; low dose
<input type="checkbox"/> Compazine/Stemetil (prochlorperazine) ≤10mg QID	___mg q ___ hours or <input type="checkbox"/> BID <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> PR <input type="checkbox"/> _____	<input type="checkbox"/> Antihistamine may prevent side-effects.
<input type="checkbox"/> Solu-medrol IV <input type="checkbox"/> Methylprednisolone	___mg ___x/day x ___days <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> High dose then taper. <input type="checkbox"/> May also need low dose x1 month.
<input type="checkbox"/> Catapres (clonidine) <input type="checkbox"/> Neurontin (gabapentin)	___mg q ___ hours or <input type="checkbox"/> QD <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> Transdermal option <input type="checkbox"/> Experimental usage
<input type="checkbox"/> Aloxi (palonosetron) <input type="checkbox"/> _____	___mg q ___ hours or <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> NEW; use with caution.
<input type="checkbox"/> Thiamin/B1 ≤500 mg/day <input type="checkbox"/> Vitamin B Complex 1-2x/day	___mg or tabs <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> To prevent Wernicke's if 2+ weeks poor intake.
<input type="checkbox"/> Multivitamin/MVI <input type="checkbox"/> Prenatal (√ amt. B1/B6 mg)	__ tabs/amp QD <input type="checkbox"/> with food or <input type="checkbox"/> PRN <input type="checkbox"/> QHS	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> Iron may ↑ nausea; try iron-free or w/food QHS.
<input type="checkbox"/> Pyridoxine/B6 ≤150 mg/day	___mg q ___ hours/QD	<input type="checkbox"/> Oral <input type="checkbox"/> SL <input type="checkbox"/> IV <input type="checkbox"/> _____	<input type="checkbox"/> >150 mg ⇔ neuropathy.
SLEEP: <input type="checkbox"/> _____	___mg q ___ hours or <input type="checkbox"/> PRN <input type="checkbox"/> QHS	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> e.g. Vistaril (hydroxyzine) <input type="checkbox"/> Poor sleep worsens HG.
GI/GERD/Constipation: <input type="checkbox"/> _____	___mg q ___ hours or <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/> H2 blockers & PPI's may improve nausea.
<input type="checkbox"/> _____	___mg q ___ hours or <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> OD <input type="checkbox"/> TD <input type="checkbox"/> SQ <input type="checkbox"/> Comp <input type="checkbox"/> IV <input type="checkbox"/> SL <input type="checkbox"/> _____	<input type="checkbox"/>

\*\*OD = Oral Dissolving, TD = Transdermal, SQ = Subcutaneous, SL = Sublingual, Comp = Compounded, PR = Rectal, PV = Vaginal  
IM not recommended due to atrophy & ↑ pain sensitivity.

## ADDITIONAL INTERVENTIONS & ASSESSMENTS

**Vitamins:**  Iron  Folic Acid  B Complex  B6 50 mg  B1 50mg/100mg  Prenatal (✓ B1)  
 Oral  Sublingual  Transdermal  Other: \_\_\_\_\_

**Nutrition:**  TPN  PPN  NG/J  G/J-Tube  Formula: \_\_\_\_\_

**Parenteral Therapy Orders:**  
 Periph IV  Midline  PICC  Central  Other: \_\_\_\_\_  
 Outpatient Clinic  Home IV  Other: \_\_\_\_\_  
 Myer's Cocktail  Banana Bag  \_\_\_ L over \_\_\_ hours  PRN  Daily  M/W/F

**Other IV Fluids:**  
 NS \_\_\_\_\_  1L  2L  3L \_\_\_ x/day over \_\_\_ hours  PRN  Daily  M/W/F  Add 100mg B1  
 LR \_\_\_\_\_  1L  2L  3L \_\_\_ x/day over \_\_\_ hours  PRN  Daily  M/W/F  Add 100mg B1  
 \_\_\_\_\_  1L  2L  3L \_\_\_ x/day over \_\_\_ hours  PRN  Daily  M/W/F  Add 100mg B1  
 MVI daily  B Complex \_\_\_ x daily  Thiamin 100mg \_\_\_ x/day  Vit K \_\_\_ mg/day  
 KCl \_\_\_\_\_  NaCl \_\_\_\_\_  Folic Acid \_\_\_\_\_ mcg daily  MgSO<sub>4</sub> \_\_\_\_\_  
 Other: \_\_\_\_\_  IV Iron \_\_\_\_\_

**Psychosocial Needs:**  Disability  FMLA  Diet Log  Other: \_\_\_\_\_  
**Home Assessment:**  Ketostix  Home RN  HG Care App  HELP Score every \_\_\_ days  
**Patient Education:**  Diet/thiamin intake  Bowel regimen  IV/enteral management  
 Serotonin Syndrome  Transdermal patch  HER HG Brochure/Referral  
 \_\_\_\_\_  TED hose/embolus prevention

### REHYDRATION RECOMMENDATIONS

- D5NS + 1 amp MVI + 100 mg thiamin + 1 mg folic acid
  - Banana Bag + B-complex
  - Myer's Cocktail + 1 ampule of MVI + 1 mg folic acid
- Note: MVI contains only 6 mg of thiamin.

### ANTIEMETIC COMBINATIONS

- 5HT3 antagonist + Promethazine
  - 5HT3 antagonist + Metoclopramide
  - 5HT3 antagonist + Corticosteroid + Metoclopramide
- Add-ons:  Vit B6 + B1  Acid reducer  Antihistamine

MD Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

### TREATMENT STRATEGIES (Acronym: HELP HER)

1. Hydration is important for treatment effectiveness.
2. Electrolytes & nutritional deficits should be corrected regularly.
3. Loss of muscle mass makes IM injections problematic.
4. Proactively address medication side-effects.
5. HER Foundation referrals offer education & support.
6. Escalate dose & change frequency/route then change/add meds.
7. Relapse common if meds stopped abruptly, wean over 2+ weeks.

### Kimber's RULE OF 2'S

Wean medications for HG:



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[www.HERFoundation.org](http://www.HERFoundation.org) & [www.HelpHER.org](http://www.HelpHER.org)  
[info@HelpHER.org](mailto:info@HelpHER.org)  
**HER is the global voice of HG**

# ALGORITHM FOR TREATMENT OF NVP

## (HELP <20)

- B6/Pyridoxine with or without doxylamine: **(Select ONE)**
  - Pyridoxine 10–25 mg PO (with or without Doxylamine 12.5 mg PO), 3 or 4 times per day.
  - Pyridoxine + Doxylamine 10 mg, two tablets PO at bedtime, add one tablet in AM & afternoon prn.
  - Pyridoxine + Doxylamine 20 mg, one tablet PO at bedtime, add AM tablet prn.
- Thiamin/Vitamin B1 50-100 mg PO 1-4 times per day.
- Continue prenatal vitamin with iron and thiamin until not tolerated → Switch to folic acid.
- Add gastric/esophageal protection. (See shaded box below.)



### Add up to 1 from each class:

- Antihistamine (discontinue doxylamine before adding)
  - Dimenhydrinate* 25-50 mg q 4–6 hours PO or PR (limit to 200 mg per day if taking doxylamine)
  - Diphenhydramine* 25–50 mg PO q 4–6 hours
  - Meclizine* 25 mg PO q 6 hours
- Dopamine Antagonist
  - Metoclopramide* 5-10 mg q 6-8 hours PO
  - Promethazine* 12.5-25 mg q 4-6 hours PO or PR
  - Prochlorperazine* 5-10 mg q 6-8 hours PO or 25 mg twice daily PR

- Daily bowel regimen
  - Stool softener 1-2x/day + Laxative prn (1-3x/week)
  - Add *Triple Mg* prn
- Ondansetron* 4-8 mg q 6-8 hours PO or ODT, or ODT given vaginally **OR**
- Granisetron* 1 mg q 12 hours PO or 3 mg q 24 hours ODT  
NOTE: Replace electrolytes & monitor EKG if high risk.

### Consider NUTRITION (see below) and one of the following:

- Mirtazapine* 15 mg q 8 hours PO or ODT (Dose not established for HG. Discontinue other serotonin antagonists.)
- Methylprednisolone* (if 10+ weeks) 16 mg q 8 hours PO or IV for 3 days. Taper over 2 weeks to lowest effective dose. Avoid duration exceeding 6 weeks.
- Prochlorperazine* 5-10 mg PO q 6-8 hours
- Chlorpromazine* 25–50 mg IV or 10–25 mg PO q 4-6 hours

### GERD or gastric/esophageal protection:

- Calcium Antacid (avoid Bismuth or Bicarbonate) **AND/OR**
- H2 antagonist BID: *ranitidine* 150 mg PO **OR** *famotidine* 20-40 mg **OR**
- PPI q 24 hours
  - esomeprazole* 30-40 mg PO or IV
  - lansoprazole* 15-30 mg PO
  - pantoprazole* 40 mg PO or IV

### Select IV Fluids:

- Banana Bag + Vit B6 + Vit B1
- Myer's Cocktail + 1 ampule MVI
- D5NS or D5LR + 1 ampule MVI + Vit B6 + Vit B1
  - Add prn: KCl, Na, Vit K, Vit D, Zn, Se, Fe, Mg & Ca.
  - Always give thiamin with glucose to prevent WE.
  - Correct electrolytes slowly to prevent CPM.
  - Restrict PO intake for 24-48 hours for gut rest.
  - Consider midline or central line for frequent IVs.

### If not responding to or tolerating PO meds, change to:

- Thiamin* 100 mg 1-5 times daily IV  
**AND ONE OF THE FOLLOWING**
  - Dimenhydrinate* 50 mg (in 50 mL saline, over 20 min) q 4–6 hours IV
  - Ondansetron*\*\*:  
    - IV: 8 mg over 15 minutes q 12 hours or 4 mg q 6 hours IV or continuous infusion
    - SubQ continuous infusion: 8 mg starting dose, then 12-40 mg/day; wean slowly to PO.
  - Granisetron*\*\* 1mg q 12 hours IV
  - Metoclopramide*:  
    - IV: 5–10 mg q 8 hours
    - SubQ continuous infusion: 5-10 mg starting dose, then 20-40 mg/day; wean slowly to PO.
- \*\* Daily Bowel Regimen required (see adjacent box)

+

### NUTRITION - If weight loss ≥10% and/or persistent HG, consult with GI & Nutrition & IV Therapy:

- Enteral therapy*: gradual infusion with or without additional parenteral/enteral fluids (Jejunal placement preferred)
- Intravenous fluids and/or parenteral nutrition*
  - Consider midline or central line.
  - Continue until gaining weight on PO intake.
  - Prevent Refeeding Syndrome: Slowly restart nutrition & monitor weight, phosphorus & electrolytes.

Disclaimer: This is not medical advice. Do not make any changes to your diet or lifestyle without consultation from your medical provider.

### NOTES:

- If symptoms persist, follow the arrows to the next level of care.
- Most of these medications can cause QT prolongation, consider EKG or cardiac monitoring for high risk patients, high doses, multiple medications, or electrolyte abnormalities.
- IM not recommended due to muscle loss and pain sensitivity.
- Avoid using multiple dopamine antagonists simultaneously.
- CPM = Central Pontine Myelinolysis; WE = Wernicke's encephalopathy
- HELP = HyperEmissis Level Prediction Score, [www.hyperemesis.org/tools](http://www.hyperemesis.org/tools)



**HER**  
Foundation

[hyperemesis.org](http://hyperemesis.org) | [HelpHER.org](http://HelpHER.org)  
Email: [info@hyperemesis.org](mailto:info@hyperemesis.org)

# HELP (HyperEmissis Level Prediction) SCORE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Gestational Age: \_\_\_\_\_ SCORE: \_\_\_\_\_

TODAY'S Weight: \_\_\_\_\_ LAST WEEK'S Weight: \_\_\_\_\_ Change: \_\_\_\_\_% PREVIOUS SCORE: \_\_\_\_\_

Meds:  Ondansetron  Granisetron  Diclegis  Promethazine  Metoclopramide  \_\_\_\_\_

Mark ONE box in EACH ROW that most accurately describes your experience over the last: \_\_\_\_\_ day(s).

<b>My nausea level most of the time:</b>	0	1 (Mild)	2	3 (Moderate)	4	5 (Severe)
<b>I average __ vomiting episodes/day:</b>	0	1-2	3-5	6-8	9-12	13 or more
<b>I retch/dry heave __ episodes daily:</b>	0	1-2	3-5	6-8	9-12	13 or more
<b>I am urinating/voiding:</b>	Same	More often, IV fluids; light or dark color	Slightly less often, and normal color	Once every 8 hours; slightly dark yellow	Less than every 8 hours or darker	Rarely; dark, blood; foul smell
<b>Nausea/vomiting severity 1 hour after meds OR after food/drink if no meds:</b>	0 or No Meds	1 (Mild)	2	3 (Moderate)	4	5 (Severe)
<b>Average number of hours I'm <u>unable</u> to work adequately at my job and/or at home due to being sick has been:</b>	0	1-2 (hours are slightly less)	3-4 (can work part time)	5-7 (can only do a little work)	8-10 (can't care for family)	11+ (can't care for myself)
<b>I have been coping with the nausea, vomiting and retching:</b>	Normal	Tired but mood is ok	Slightly less than normal	It's tolerable but difficult	Struggling: moody, emotional	Poorly: irritable depressed
<b>Total amount I have been able to eat/drink AND keep it down: <i>Medium water bottle/large cup = 2 cups/500mL.</i></b>	Same; no weight loss	Total of about 3 meals & 6+ cups fluid	Total of about 2 meals & some fluid	1 meal & few cups fluid; only fluid or only food	Very little, <1 meal/minimal fluids; frequent IV	Nothing goes or stays down, or daily IV/TPN/NG
<b>My anti-nausea/vomiting meds stay down/are tolerated:</b>	No meds	Always	Nearly always	Sometimes	Rarely	Never/IV/SQ (subQ pump)
<b>My symptoms compared to last week:</b>	Great	Better	About Same	Worse	Much Worse	So Much Worse!!!
<b>Weight loss over last 7 days: ____%</b>	0%	1%	2%	3%	4%	5%
<b>Number of Rx's for nausea/vomiting*</b>	0	1	2	3	4	5+
	<b>0 pts</b>	<b>1 pt/answer</b>	<b>2 pts/answer</b>	<b>3 pts/answer</b>	<b>4 pts/answer</b>	<b>5 pts/answer</b>
<b>TOTAL each column = (#answers in column) x (# points for each answer)</b>	0	_____	_____	_____	_____	_____
<b>TOTAL for ALL columns: _____</b>	<b>None/Mild ≤ 19</b>		<b>Moderate 20-32</b>		<b>Severe 33-60</b>	

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Weight Loss % = (Amount lost ÷ Pre-pregnancy weight) x 100  
(Weight loss calculation optional for home use)

\* Number of Rx's = Number of Rx medications (not doses)



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The Global Voice of HG

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