

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) _____ Date of Diagnosis: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.) NORMAL SALINE

2.) LACTATED RINGERS

<input type="checkbox"/> 500 mL, IV x _____	<input type="checkbox"/> 500 mL, IV x _____
<input type="checkbox"/> 1000 mL (1 Liter), IV x _____	<input type="checkbox"/> 1000 mL (1 Liter), IV x _____
<input type="checkbox"/> 2000 mL (2 Liters), IV x _____	<input type="checkbox"/> 2000 mL (2 Liters), IV x _____

RATE

RATE

<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR	<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR
<input type="checkbox"/> Over 2 hours @ _____ mL/hour	<input type="checkbox"/> Over 2 hours @ _____ mL/hour
<input type="checkbox"/> Over 4 hours @ _____ mL/hour	<input type="checkbox"/> Over 4 hours @ _____ mL/hour
<input type="checkbox"/> Other: _____ mL/hour	<input type="checkbox"/> Other: _____ mL/hour

_____ MEQ K+ _____ MG MAG _____ Lidocaine 1% 2 mL OTHER: _____ RATE MAY BE ADJUSTED PER HOSPITAL POLICY
 (K+ max rate of 10mEq/hr)

OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW:

LABS:

NOTES/INSTRUCTIONS/COMMENTS

SELECT	LAB REQUESTED	FREQUENCY	
<input type="checkbox"/>	NONE	NONE	
<input type="checkbox"/>	CBC w/ Diff	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.