Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

IV HYDRATION ORDER

Please fax a copy of patient's demographics, insurance information, H&P relevant to the diagnosis & current medications

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

HYDRATION SOLUTION ☐ **0.9% Sodium Chloride** ☐ **Dextrose 5% w/ Lactated Ringers**
☐ **Lactated Ringers** ☐ **Dextrose 5% w/ 0.9% Sodium Chloride**

IV MEDICATION

☐ **Zofran _____ mg IV Q _____** ☐ **Other _____**

VOLUME TO BE INFUSED AT EACH VISIT: ☐ **500 mL** ☐ **1000 mL**
☐ **2000 mL** ☐ **Other _____**

Over _____ hours

FREQUENCY: _____ DURATION: _____

START DATE OF INFUSION: _____/_____/_____

OTHER ORDERS OR SPECIAL INSTRUCTIONS: _____

_____

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____