IV Hydration Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to the Diagnosis ☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

HYDRATION ORDER

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: _____

_____

Revised 12/01/20