Infusion Associates
Phone: 616-954-0600 Fax: 616-954-1675

IV Hydration Orders

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:_____**

DX CODES: ***ICD-10*** : **_____, _____, _____**

Start Date of Infusion: _____/_____/_____ **End Date of Infusion: _____/_____/_____**

PLEASE CHOOSE A SOLUTION AND VOLUME

Hydration solution to be given via IV route:

- ☐ Dextrose 5%
- ☐ Dextrose 5% w/ 0.45% Sodium Chloride
- ☐ Dextrose 5% w/ 0.9% Sodium Chloride
- ☐ Lactated Ringers
- ☐ Dextrose 5% w/ Lactated Ringers
- ☐ 0.45% Sodium Chloride
- ☐ 0.9% Sodium Chloride

Volume to be infused at each visit:

- ☐ 500 mL
- ☐ 1000 mL
- ☐ 2000 mL
- ☐ Other:_____mL

IV Medications / Additives: Please select total dose to be given at each visit:

- ☐ None
- ☐ Potassium Chloride _____ mEq
- ☐ Magnesium Sulfate _____ gm
- ☐ Zofran _____ mg
- ☐ Phenergan (if NOT driving) _____ mg
- ☐ Other _____

Frequency / Duration: _____

Labs: ☐ None ☐ Yes: _____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ **Fax Number:** _____