Infusion ASSOCIATES

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

Hydration/Electrolytes/Anti-Emetic IV Infusion

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

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

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

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

ICD-10 : _____, _____, _____

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ Magnesium ☐ Other: _____

Lab Frequency: ☐ ONCE at first infusion ☐ Every infusion ☐ Other:_____

☐ Pharmacist to select fluid based on compatibility

IV Hydration:

- ☐ Dextrose 5% w/ 0.45% Sodium Chloride
- ☐ Dextrose 5% w/ 0.9% Sodium Chloride
- ☐ Dextrose 5% w/ Lactated Ringers
- ☐ Lactated Ringers
- ☐ 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
- ☐ Folic Acid _____ mg
- ☐ Magnesium Sulfate _____ gm
- ☐ Phenergan _____ mg
- ☐ Potassium Chloride _____ mEq *(only available in 20 mEq in 1000mL)*
- ☐ Thiamine _____mg
- ☐ Zofran _____ mg
- ☐ Other _____

Frequency:

☐ ONCE ☐ Daily ☐ Every other day ☐ Three times a week ☐ Weekly ☐ PRN ☐ Other:_____

Rx Expiration Date: _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

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