Phone: (833) 394-0600 Fax: (833) 996-4888

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:** ______________________________

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _______________