IV Hydration Infusion Order

Please provide 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 : _____, _____, _____

IV Hydration:

- ❑ Lactated Ringers 1000 mL
- ❑ 0.9% Sodium Chloride 1000 mL
- ❑ Lactated Ringers 2000 mL
- ❑ 0.9% Sodium Chloride 2000mL

IV Medications / Additives:

- ❑ None
- ❑ Diphenhydramine _____ mg
- ❑ Magnesium Sulfate _____ gm
- ❑ Promethazine _____ mg
- ❑ Ketorolac _____mg
- ❑ Metoclopramide _____mg
- ❑ Ondansetron _____ mg
- ❑ Other _____

Rx Expiration Date: _____/_____/_____ Printed Provider Name: _____

Provider Signature: _____

Office Phone Number:_____