SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

# HYDRATION ORDER FORM

## PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

## STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) _____ Date of Diagnosis: _____

## PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

## PRESCRIPTION ORDERS FOR HYDRATION

**Select the fluid requested AND the corresponding rate below**

| **1.) ☐ NORMAL SALINE** | **2.) ☐ LACTATED RINGERS** |
|---|---|
| **☐ 500 mL, IV x** | **☐ 500 mL, IV x** |
| **☐ 1000 mL (1 Liter), IV x** | **☐ 1000 mL (1 Liter), IV x** |
| **RATE** | **RATE** |
| **☐ BOLUS - GIVEN OVER 1 HOUR** | **☐ BOLUS - GIVEN OVER 1 HOUR** |
| **☐ Over 2 hours @ mL/hour** | **☐ Over 2 hours @ mL/hour** |
| **☐ Over 4 hours @ mL/hour** | **☐ Over 4 hours @ mL/hour** |
| **☐ Other: mL/hour** | **☐ Other: mL/hour** |

**☐ ADDITIVES: ○ _____ MEQ K+ ○ _____GM MAG PIGGY BACK ○ OTHER:_____ RATE MAY BE ADJUSTED PER HOSPITAL POLICY**

**(K+ max rate of 10mEq/hr)**

**OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW:**

_____

**LABS:**

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| | NONE | NONE |
| | CBC w/ Diff | ( ) PRIOR ( ) POST |
| | BMP | ( ) PRIOR ( ) POST |
| | CMP | ( ) PRIOR ( ) POST |
| | BUN/CREATININE | ( ) PRIOR ( ) POST |
| | Other: | ( ) PRIOR ( ) POST |

**NOTES/INSTRUCTIONS/COMMENTS**

_____

_____

_____

_____

_____

**Physician's Signature** _____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

**Cosignature (If Required)**_____ **Time**_____ **Date**_____

**Signature Must Be Clear and Legible*

**Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.**