IV Hydration (Sodium Chloride, Lactated Ringers)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS ***(Please provide ICD-10 code in space provided)***

Dehydration:

Other: Description:

THERAPY ADMINISTRATION ***(Choose one)***

☐ 0.9% sodium chloride _____ ml to infuse over _____ hours
☐ 0.45% sodium chloride _____ ml to infuse over _____ hours
☐ Lactated Ringers _____ ml to infuse over _____ hours

FREQUENCY ***(Choose one)***

☐ Every _____ days
☐ Every _____ weeks
☐ Once

ADDITIONAL ORDERS

☐ Ok to leave IV in for treatment on consecutive days.

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST ***(Additional documentation required for processing and insurance approval)***

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name ***(print)*** **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.