SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician 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 OR HEPARIN PER HOSPITAL POLICY

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_____**
☐ **2000 mL (2 Liters), IV x_____**	☐ **2000 mL (2 Liters), 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**

○ _____ **MEQ K+** ○ _____**MG MAG** ○ _____ **Lidocaine 1% 2 mL** ○ **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	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.