



Hydration

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment: _____

Orders

Initiate IV Vascular Access Flush Orders #0643 for: Peripheral Line Midline PICC Port

Normal Saline 0.9% Solution _____ milliliter/hour INTRAVENOUS (J7030 : 1000 ML = 1 unit)

Lactated Ringers Solution _____ milliliter/hour INTRAVENOUS (J7030 : 1000 ML = 1 unit)

Rally Pack INTRAVENOUS ONCE over 4 hours:

Normal Saline 1000 mL Solution (J7030 : 1000 ML = 1 unit)

Magnesium Sulfate 2 GM (J3475 : 500 MG = 1 unit)

Thiamine 100 MG (J3411 : 100 MG = 1 unit)

MVI 10 ML (J3490 : 1 ML = 1 unit)

Folic Acid 1 MG (J3490 : 1 MG = 1 unit)

Albumin 25% _____ mLs INTRAVENOUS OVER 2 HOURS followed by Normal Saline 0.9% Solution 2000 mL INTRAVENOUS OVER 2 HOURS.

Other: _____

Discharge Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE: _____
07952512

TIME: _____

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PHYSICIAN'S SIGNATURE

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES