Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

HYDRATION ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI____ DOB:____________

HT: _________ in WT: ________ 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.