



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 PROTOCOL

PRESCRIPTION ORDERS FOR HYDRATION

Select the fluid requested AND the corresponding rate below

1.) NORMAL SALINE

2.) LACTATED RINGERS

<input type="checkbox"/> 500 mls, IV x	<input type="checkbox"/> 500 mls, IV x
<input type="checkbox"/> 1000 mls (1 Liter), IV x	<input type="checkbox"/> 1000 mls (1 Liter), IV x
<input type="checkbox"/> 2000 mls (2 Liters), IV x	<input type="checkbox"/> 2000 mls (2 Liters), IV x
RATE	RATE
<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR	<input type="checkbox"/> BOLUS - GIVEN OVER 1 HOUR
<input type="checkbox"/> Over 2 hours @ _____ mls/hour	<input type="checkbox"/> Over 2 hours @ _____ mls/hour
<input type="checkbox"/> Over 4 hours @ _____ mls/hour	<input type="checkbox"/> Over 4 hours @ _____ mls/hour
<input type="checkbox"/> Other: _____ mls/hour	<input type="checkbox"/> Other: _____ mls/hour
<input type="checkbox"/> ADDITIVES: <input type="radio"/> _____ MEQ K+ <input type="radio"/> _____ MG MAG <input type="radio"/> 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