Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
HYDRATION ORDER FORM

☐ **STAT REFERRAL**

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**

☐ **500 mls, IV x**	☐ **500 mls, IV x**
☐ **1000 mls (1 Liter), IV x**	☐ **1000 mls (1 Liter), IV x**
☐ **2000 mls (2 Liters), IV x**	☐ **2000 mls (2 Liters), IV x**

RATE	**RATE**
☐ **BOLUS - GIVEN OVER 1 HOUR**	☐ **BOLUS - GIVEN OVER 1 HOUR**
☐ **Over 2 hours @ mls/hour**	☐ **Over 2 hours @ mls/hour**
☐ **Over 4 hours @ mls/hour**	☐ **Over 4 hours @ mls/hour**
☐ **Other: mls/hour**	☐ **Other: mls/hour**

☐ **ADDITIVES:** ○ _____ **MEQ K+** ○ _____**MG MAG** ○ **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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.