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

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES

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.