



Infusion Associates
 3230 Eagle Park NE, Suite 101
 Grand Rapids, MI 49525
 Phone: 616-954-0600 Fax: 616-954-1675

IV Hydration Orders

**Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

DX CODES: ICD-10 : _____, _____, _____

Start Date of Infusion: ____/____/____ End Date of Infusion: ____/____/____

PLEASE CHOOSE A SOLUTION AND VOLUME

Hydration solution to be given via IV route:

- Dextrose 5%
- Dextrose 5% w/ 0.45% Sodium Chloride
- Dextrose 5% w/ 0.9% Sodium Chloride
- Lactated Ringers
- Dextrose 5% w/ Lactated Ringers
- 0.45% Sodium Chloride
- 0.9% Sodium Chloride

Volume to be infused at each visit:

- 500 mL
- 1000 mL
- 2000 mL
- Other: _____ mL

IV Medications / Additives: Please select total dose to be given at each visit:

- None
- Potassium Chloride _____ mEq
- Magnesium Sulfate _____ gm
- Zofran _____ mg
- Phenergan (if NOT driving) _____ mg
- Other _____

Frequency / Duration: _____

Labs: None Yes: _____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ Fax Number: _____