Hydration

Infusion Order Form – Page 1 of 1

Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis
- Include signed and completed order (MD/prescriber to complete page 1)
- Labs attached:
  - Serum potassium (if order contains KCL)
- PICC/Central line placement confirmation (if applicable)

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

THERAPY

FLUID

☐ Normal Saline
☐ D5 1/2 NS
☐ 1/2 Normal Saline
☐ D5LR
☐ D5NS
☐ Lactated Ringers

VOLUME

☐ 1 Liter (1000mL)
☐ 2 Liter (2000mL)
☐ 500mL
☐ Other: _____mL

FREQUENCY

☐ One time dose _____
☐ _____times per week
☐ Other _____

RATE OF ADMINISTRATION

☐ Bolus, as tolerated
☐ Over 1 hour
☐ Over 2 hours
☐ Over _____hours

Additional IV additive medications for infusion:

☐ MVI
☐ Mag sulfate IV: ☐ 1 gm / ☐ 2 gm
☐ Other _____

Additional medications for IVP:

Zofran IVP: ☐ 4mg / ☐ 8mg
Reglan IV: ☐ 10mg
Pepcid IVP: ☐ 20mg
Protonix IVP: ☐ 40mg
☐ Other IV: Dose: _____

Regimen duration (if > than one time dose):

☐ 1 week ☐ 30 days ☐ 3 months ☐ 6 months
☐ Other: _____ ☐ until, date: _____

☐ Patient is required to stay for 60 min. observation

Provider Name (Print): Provider Signature: Date:

Harbor Health