Hydration Referral Form

BURNHAM'S vitalcare

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:

☐ Dehydration (ICD-10 _____)

☐ Other (ICD-10 _____)

Dispense: ☐ 1 L Sodium Chloride 0.9% IV ☐ 2 L Sodium Chloride 0.9% IV

Rate: ☐ 250 mL/hr ☐ 500 mL/hr ☐ Other: _____

Frequency: ☐ Weekly ☐ Twice weekly ☐ Three times weekly

Refill: ☐ PRN x 1 year OR _____ times

Line Type: ☐ PIV ☐ Midline ☐ PICC ☐ Port ☐ Tunneled Catheter

Supply Orders: ☐ Pharmacy to provide IV fluids and dial-a-flow administration tubing and may dispense a 4-week supply

Nursing Orders: ☐ Nursing supplies and services to be provided by _____

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

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