Hydration Referral Form

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: