ADVANCED
INFUSION CENTER

Hydration Infusion Orders

Name: _____ DOB: _____

Allergies: _____ Weight: _____

Diagnosis (ICD 10 required): _____

___ Dehydration ___ Gastroenteritis __ Nausea/vomiting __ Electrolyte imbalance

___ Hyperemesis of Pregnancy __ Postural orthostatic hypotension (POTS)

___ Other: _____

Therapy Order: circle one

___ Normal saline ___ D51/2 NS __ ½ Normal saline __ D5LR ___ D5NS

___ Lactated Ringers ___ Other: _____

Volume: ____ 500 ml ____1000 ml ____2000 ml ____Other: _____

IV additive medications for infusion: ___ MVI ___ Magnesium sulfate grams: _____

Potassium chloride: ___ 20 mEq ___ 40 mEq (infuse each 10 mEq over 1 hour)

Zofran IVP: ___ 4 mg ___ 8 mg

Therapy duration: ___ once weekly __ twice weekly ___ thrice weekly

other: _____ ___ PRN until, date: _____

Lab orders: _____

Physician signature: _____ Date: _____

Physician name (printed): _____

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