

HYDRATION ORDER

Patient's Name (Last, First, Middle) _____ DOB: _____

Patient's height in ft/in: _____ Patient's weight in lbs: _____

■ **Diagnosis** Please provide the most specific ICD-10 code.

- | | | |
|--|--|---|
| <input type="checkbox"/> _____ Alcohol Intoxication | <input type="checkbox"/> _____ Gastroenteritis | <input type="checkbox"/> _____ Sleep Disorder |
| <input type="checkbox"/> _____ Dehydration | <input type="checkbox"/> _____ Nausea | <input type="checkbox"/> _____ Vomiting |
| <input type="checkbox"/> _____ Electrolyte Imbalance | <input type="checkbox"/> _____ Pregnancy Hyperemesis | <input type="checkbox"/> _____ |

■ **Fluid Orders**

- | | | |
|--|---|--|
| <input type="checkbox"/> Normal Saline | <input type="checkbox"/> D5 (5% Dextrose) | <input type="checkbox"/> Lactated Ringers (Hartmann's) |
|--|---|--|

■ **Fluid Volume**

- | | | |
|--------------------------------|--------------------------------|---------------------------------|
| <input type="checkbox"/> 250ml | <input type="checkbox"/> 500ml | <input type="checkbox"/> 1000ml |
|--------------------------------|--------------------------------|---------------------------------|

■ **Additional Medication Orders**

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Benadryl 50mg | <input type="checkbox"/> Pepcid 20mg | <input type="checkbox"/> Toradol 30mg |
| <input type="checkbox"/> Multi-Vitamin (Infuvite) | <input type="checkbox"/> Reglan 2mg | <input type="checkbox"/> Zofran (circle) 4mg <u>or</u> 8mg |

■ **Rate of Administration**

- | | | |
|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Over ~30 minutes | <input type="checkbox"/> Over 1 hour | <input type="checkbox"/> Over _____ |
|---|--------------------------------------|-------------------------------------|

■ **Frequency**

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> One time only | <input type="checkbox"/> Standing order, up to _____ times over _____ months | <input type="checkbox"/> Other _____ |
|--|--|--------------------------------------|

■ **Notes**

■ **Rescue Management in case of Infusion Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.