



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

IV Hydration and Electrolytes

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ___/___/___ Site of Service: TH Muskegon TH Shelby

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____

Primary Insurance: _____

Date of Birth: ___/___/___

Member ID: _____

Weight: ___kg Height: ___cm

Secondary Insurance: _____

Allergies: _____

Member ID: _____

<p style="text-align: center;">Diagnosis</p> <p>Diagnosis Code (ICD-10): _____</p> <p>Indication: _____</p> <p>Target start date: _____</p>	<p style="text-align: center;">Labs: <input type="checkbox"/> Once <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other:</p> <p><input type="checkbox"/> Basic Metabolic Panel <input type="checkbox"/> Complete Blood Count</p> <p><input type="checkbox"/> Magnesium <input type="checkbox"/> Other: _____</p>
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Pre-Medications

Ondansetron (Zofran) IV 4 mg Dexamethasone (Decadron) injection ___ mg Prochlorperazine (Compazine) tablet 10 mg

Other: _____

IV Hydration and/ or Electrolytes or Multivitamin to be Administered

<u>Standard Infusion</u>	<u>Custom Infusion</u>
<p><i>Normal Saline</i></p> <p><input type="checkbox"/> Sodium chloride 0.9 %</p> <p><input type="checkbox"/> Sodium chloride 0.9 % with KCl 20 mEq/L</p> <p><input type="checkbox"/> Sodium chloride 0.9 % with KCl 40 mEq/L</p> <p><i>Dextrose-containing solutions</i></p> <p><input type="checkbox"/> Dextrose 5%</p> <p><input type="checkbox"/> Dextrose 5% and sodium chloride 0.45%</p> <p><input type="checkbox"/> Dextrose 5% and lactated ringer's</p> <p><input type="checkbox"/> Lactated Ringer's</p> <p><input type="checkbox"/> Other fluid: _____ ml</p> <p>Volume to be administered: _____ ml over _____ hr</p>	<p><i>Base:</i></p> <p><input type="checkbox"/> Sodium chloride 0.9 %</p> <p><input type="checkbox"/> Sodium chloride 0.45 %</p> <p><input type="checkbox"/> Dextrose 5% (D5W)</p> <p><input type="checkbox"/> D5W and sodium chloride 0.2%</p> <p><input type="checkbox"/> Dextrose 5 % and sodium chloride 0.45 %</p> <p><input type="checkbox"/> Dextrose 5 % and sodium chloride 0.9 %</p> <p><input type="checkbox"/> Lactated Ringer's</p> <p><i>Additive(s):</i> [Per Infusion Visit]</p> <p><input type="checkbox"/> MVI 10 ml</p> <p><input type="checkbox"/> Potassium chloride <input type="checkbox"/> 20meq <input type="checkbox"/> 40mEq</p> <p><input type="checkbox"/> Thiamine <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg</p> <p><input type="checkbox"/> Folic Acid 1 mg</p> <p><input type="checkbox"/> Magnesium sulfate <input type="checkbox"/> 1g <input type="checkbox"/> 2g</p> <p><input type="checkbox"/> Calcium gluconate _____ g</p> <p><input type="checkbox"/> Pyridoxine _____ g</p> <p>Volume to be administered: _____ ml over _____ hr</p>
<p style="text-align: center;"><u>Electrolyte Replacement</u></p> <p><input type="checkbox"/> Calcium gluconate injection _____ g (rate: 1g/hr)</p> <p><input type="checkbox"/> Potassium chloride IVPB _____ mEq (rate: 10meq/hr)</p> <p><input type="checkbox"/> Magnesium sulfate IV _____ g (rate: 1g/hr)</p>	

Frequency

Daily (Monday- Friday) x ___ doses Tuesday and Thursday x ___ doses Monday, Wednesday, and Friday x ___ doses

Once Other: _____

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy, if necessary

sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN.

Provider Name: _____	Provider Signature: _____
Office Phone Number: _____	Office Fax Number: _____
Attending Physician Name: _____	
<i>(If ordering provider is an advanced practice practitioner, attending physician name required)</i>	
<i>Note: This order is valid for 12 months from date of physician signature.</i>	