Northwestern Medicine

IV Hydration

Order Processing: Fax Form:		
CDH PTC: Fax (630) 933-2444 *Phone (630)933-6272*		
Delnor OPIC: Fax (630)208-3467 *Phone (630)208-4446*		
Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Diagnosis and Code REQUIRED for submitting form

Diagnosis:_____Code:_____

Please complete all applicable fields to avoid any delays in scheduling or phone calls for clarification.

Attention provider: Nursing to enter a future lab orders prior to discharge for the following: circle all that apply and define the frequency for the lab draw (example: daily, prior to each infusion, weekly {Monday, Tuesday, Wednesday, Thursday, Friday}, every other week, once a month)

Lab	*Frequency*	*Or #*
BMP		
BUN		
CBC		
CBC-Diff		
CMP		
CK		
Creatinine		
CRP		
ESR		
Iron Studies (Ferritin, Iron, Transferrin, TIBC)		
Hepatic Function		
PT/INR		

Nursing Orders

- ☑ **Infusion Nurse to assess the patient's vascular access and initiate orders for line care per department policies and procedures.**

IV Fluids:

- ☐ Sodium chloride 0.9%, _____ mL/hr, 1000 mL, continuous infusion, Once
- ☐ D5 LR _____mL/hr, 1000 mL, continuous infusion, Once
- ☐ D5 NACL _____mL, 1000 mL, continuous infusion, Once
- ☐ Other_____

_____

Provider Name: _____Signature:_____

Date: _____ Time: _____