

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

Hydration Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: <input type="checkbox"/> See list <input type="checkbox"/> NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="text"/>	- Other:
<input type="text"/>	- Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5		THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

MEDICATION/DOSE:

<input type="checkbox"/>	0.9% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	0.45% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	Dextrose 5% in 0.9% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	Dextrose 5% in Lactated Ringers IV - _____ ml
<input type="checkbox"/>	Other: _____ - _____ ml
<input type="checkbox"/>	Additives: _____

INFUSION RATE: (Will be given at a rate of 500ml/hour unless otherwise indicated below)

Alternative infusion rate: _____

FREQUENCY:

One time dose Other: _____

DURATION:

_____ Weeks _____ Months

SPECIAL/LAB ORDERS:

Refills sufficient for duration unless otherwise noted here:

NURSING ORDERS:

Start PIV/Access CVC
 Flush device per facility standard flushing procedure
 Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

<input type="text"/>	<input type="text"/>
Dispense as written/Brand medically necessary	Substitution permitted