Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Rev. 4.28.25

Hydration Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:							
Patient's Phone:		Address:					
Date of Birth:		City, State, Zip:					
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐	See list	☐	NKDA

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

☐ _____ - Other:

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5			☐ **Continue current order until insurance approved**
6			

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:

☐ 0.9% Sodium Chloride IV - _____ml

☐ 0.45% Sodium Chloride IV - _____ml

☐ Dextrose 5% in 0.9% Sodium Chloride IV - _____ml

☐ Dextrose 5% in Lactated Ringers IV - _____ml

☐ Other:_____ - _____ml

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.

PRESCRIBER INFORMATION:

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

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	