Hy-Vee health
INFUSION CARE

IV FLUID Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

☐ Congestive heart failure - ejection fraction %: _____ ☐ Diabetes

☐ Renal impairment ☐ Other cardiac history: _____ ☐ Other history: _____

Diagnosis – (ICD-10)

☐ Dehydration: _____ ☐ Gastroenteritis: _____ ☐ Nausea/Vomiting: _____

☐ Electrolyte imbalance: _____ ☐ Hyperemesis of pregnancy: _____ ☐ Other: _____

Fluid

☐ Normal saline ☐ D5NS – (D5 normal saline) ☐ .45 normal saline ☐ D5 lactated ringers

☐ D5NS – (D5 normal saline) ☐ Lactated ringers ☐ Other: _____

Volume

☐ 1 Liter (1000 mL)

☐ 2 Liter (2000 mL)

☐ Other: _____

Frequency

☐ 1 time dose _____

☐ _____ times per week

☐ Other: _____

Rate of Administration

☐ Bolus, as tolerated

☐ Over 1 hour ☐ Over 2 hours

☐ Over _____ hours

Additional IV Medications

Zofran IVP: ☐ 4 mg ☐ 8 mg **Reglan IV:** ☐ 10 mg – 100 mL NS **Pepcid IV:** ☐ 20mg IV **KCL:** ☐ 20 Eq in 1000 mL NS

Protonix IV: ☐ 40 mg **MVI (infuvite):** ☐ 1 AMP in 1000 mL NS

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

☐ Clinical/progress notes, labs and test supporting primary diagnosis

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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