Holland Hospital

AMBULATORY TREATMENT UNIT

IV Hydration Order Set

Phone (616) 394-3547
Fax (616) 394-2139

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

LABS

- ☐ None
- ☐ CMP ☐ CBC ☐ Magnesium ☐ BMP ☐ C-Diff ☐ Other: _____

IV Fluids: (IV fluid rate per Holland Hospital policy)

- ☐ Lactated Ringers
- ☐ 0.9% Sodium Chloride
- ☐ Other: _____

VOLUME TO BE INFUSED:

- ☐ 1000 mL
- ☐ 2000 mL

IV Medications / Additives: Please select total dose to be given at visit:

- ☐ None
- ☐ Thiamine IV 100 mg
- ☐ Folic Acid IV 1 mg
- ☐ Potassium Chloride 20 mEq
- ☐ Zofran 4 mg IV push
- ☐ Dexamethasone (Decadron) 10 mg IV push
- ☐ Other: _____

THIS ORDER IS VALID FOR:

- ☐ ONE VISIT
- ☐ TWO VISITS
- ☐ Other: _____

Notes:

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____