



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: _____

LAB ORDER IS VALID FOR:

- ☐ ONE VISIT
☐ TWO VISITS
☐ 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: _____

