Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER

IV Hydration

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _______/_______/________

*__Please fax a copy of the following patient information__: ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

Patient Information

Allergies: ________________________________

Weight: ____________ lbs/kg Height: _______

Diagnosis: ________________________________

ICD-10: __________________________________

Provider Information

Printed Provider's Name: _______________________

Signature: _________________________________

NPI: ___________________ Date: ___/_____/______

Phone: (____)_____-______ Fax: (____)____-______

Office Address: ______________________________

Contact Person: ______________________________

Hydration Order

Hydration Solution: ☐ 0.9% Sodium Chloride

☐ Lactated Ringers

☐ Other: ____________________________________

IV Medication: ☐ Zofran ________ mg IV

☐ Other: __________

Volume to be Infused at Each Visit: ☐ 500 mL ☐ 1000 mL ☐ 2000 mL ☐ Other: ______

Over: _______________ hours

Frequency: _____________________________ Duration: _____________________________

Start Date of Infusion: ____/____/____

Other Orders or Special Instructions: ____