



Normal Saline 0.9 IV Infusion Order Form

Phone: 405-442-7577 Fax: 405-442-7223 \\
email: orders@premierinfusioncenter.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg/lb **Height:** _____ cm/in
- **Allergies:** NKDA _____
- **Treatment Status:** New Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

- E86.0 – Dehydration
- O21.1 – Hyperemesis Gravidarum
- E86.1 – Hypovolemia
- E86.1 – Volume Depletion
- Other: _____ **ICD-10 Code:** _____

Infusion Order

- 1000 mL 0.9% sodium chloride
- 500ml 0.9% sodium chloride
- Maintenance: Every ____ weeks
- Infuse over 60-90 minutes
- PRN: _____
- Observation: 30 minutes post-infusion
- Refills: None 12 months Other: _____

Line Use & Access

- Start PIV Access CVC Use PICC Line Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

- Premier Infusion Center Protocol (premierinfusioncenter.com)
 Other – please fax preferred reaction orders to 405-442-7223

Premedication (Optional)

- Acetaminophen: 500 mg 650 mg 1000 mg PO
 Diphenhydramine: 25 mg 50 mg PO IV
 Cetirizine: 10 mg PO
 Zofran:
 Hydrocortisone: 100 mg IV
 Other: _____ **Dose:** _____ **Route:** _____

Clinical Documentation Checklist

- Recent progress notes Last H&P Lab results Medication list
 Documentation of prior therapies or intolerance

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / ____ / ____