Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

IV Hydration and Electrolytes

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____
Date of Birth: ____/____/____
Weight: _____kg **Height:** _____cm
Allergies: _____

Primary Insurance: _____
Member ID: _____
Secondary Insurance: _____
Member ID: _____

Diagnosis

Diagnosis Code (ICD-10): _____
Indication: _____
Target start date: _____

Labs: ☐ Once ☐ Daily ☐ Weekly ☐ Other:

☐ Basic Metabolic Panel ☐ Complete Blood Count
☐ Magnesium ☐ Other: _____

Pre-Medications

☐ Ondansetron (Zofran) IV 4 mg ☐ Dexamethasone (Decadron) injection ____ mg ☐ Prochlorperazine (Compazine) tablet 10 mg
☐ Other: _____

IV Hydration and/ or Electrolytes or Multivitamin to be Administered

Standard Infusion

Normal Saline
☐ Sodium chloride 0.9 %
☐ Sodium chloride 0.9 % with KCl 20 mEq/L
☐ Sodium chloride 0.9 % with KCl 40 mEq/L

Dextrose-containing solutions
☐ Dextrose 5%
☐ Dextrose 5% and sodium chloride 0.45%
☐ Dextrose 5% and lactated ringer's
☐ Lactated Ringer's
☐ Other fluid: _____ ☐_____ml
Volume to be administered: _____ml over _____hr

Electrolyte Replacement

☐ Calcium gluconate injection _____ g (rate: 1g/hr)
☐ Potassium chloride IVPB _____ mEq (rate: 10meq/hr)
☐ Magnesium sulfate IV _____ g (rate: 1g/hr)

Custom Infusion

Base:
☐ Sodium chloride 0.9 %
☐ Sodium chloride 0.9 %
☐ Dextrose 5% (D5W)
☐ D5W and sodium chloride 0.2%
☐ Dextrose 5 % and sodium chloride 0.45 %
☐ Dextrose 5 % and sodium chloride 0.9 %
☐ Lactated Ringer's
Additive(s): [Per Infusion Visit]
☐ MVI 10 ml
☐ Potassium chloride ☐ 20meq ☐ 40mEq
☐ Thiamine ☐ 100 mg ☐ 200 mg
☐ Folic Acid 1 mg
☐ Magnesium sulfate ☐ 1g ☐ 2g
☐ Calcium gluconate _____ g
☐ Pyridoxine _____ g
Volume to be administered: _____ml over _____hr

Frequency

☐ Daily (Monday- Friday) x ____doses ☐ Tuesday and Thursday x ____ doses ☐ Monday, Wednesday, and Friday x ____ doses
☐Once ☐ Other: _____

Nursing Orders:
Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy, if necessary
sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN.

Provider Name: _____
Office Phone Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner)
Note: This order is valid for 12 months from date of physician signature.

Provider Signature: _____
Office Fax Number: _____