FirstHealth OF THE CAROLINAS

7096.08.16148.01 Sunset Date: 6/2024

OP IV Hydration Referral

3POREF001

Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
- ☐ Moore Regional Hospital (MRH)
- ☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments ☐ Until _____

Nursing Orders	Interval	Duration
☐ Insert peripheral IV Once	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous, As needed, line care	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once 500 Units, intravenous, Once	_____	_____

Provider Signature: _____ **Date:** _____ **Time:** _____

* May be used as EPIC Downtime Form

Place Patient Label
Inside This Box

OP Hydration	Interval	Duration
☐ dextrose 5 % infusion 500 mL 500 mL, intravenous, Once	_____	_____
☐ dextrose 5 % infusion 1,000 mL 1,000 mL, intravenous, Once	_____	_____
☐ D5 % and 0.9 % sodium chloride infusion intravenous, Once	_____	_____
☐ D5 % and 0.45 % sodium chloride infusion 500 mL 500 mL, intravenous, Once	_____	_____
☐ D5 % and 0.45 % sodium chloride infusion 1,000 mL 1,000 mL, intravenous, Once	_____	_____
☐ Sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, Once	_____	_____
☐ Sodium chloride 0.9 % infusion 1,000 mL 1,00 mL, intravenous, Once	_____	_____

RATE _____ ml/hr

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

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