ISLAND INFUSION CENTER

1211 24th St.1015 25th Street, Upper Level
Anacortes, WA 98221

Phone: 360.299.4200
Fax: 360.299.4237

PROVIDER ORDER FORM

Fluids and Anti-emetics

- Please complete form, and fax with latest clinical documentation to 360.299.4237.
- Include latest lab values.

Patient Name (First, Middle, Last): _____ D.O.B. _____

Allergies: _____ Is the patient pregnant? ☐ Yes ☐ No

Diagnosis: _____ICD-10 Code: _____

Pre-auth Done? ☐ Not required ☐ Yes Authorization #: _____ Authorization Dates: _____

Hydration:

☐ Normal Saline (J7030): Infuse 1000 mL IV over 1 hour PRN up to _____days/week

☐ Lactated Ringers (J7120): Infuse 1000 mL IV over 1 hour PRN up to _____days/week.

☐ _____: Infuse _____mL IV over _____ hour(s) PRN up to _____days/week.

Antiemetic Medication:

☐ Ondansetron (J2405): ☐ 4 mg or ☐ 8 mg IV once/visit PRN nausea/vomiting

☐ Famotidine (J3490): 20 mg IV once/visit PRN heartburn r/t vomiting

☐ Other: _____

☒ In case of infusion reaction, orders will be carried out per Island Health Policy unless crossed out.

- Stop infusion, obtain VS and assessment, call Provider*
- NS 0.9% 1000 mL/hour IV for blood pressure <100/60
- O_2 per nasal cannula to maintain saturation >92%
- Diphenhydramine 25 mg IV x1 dose
- Methylprednisolone succ 125 mg IV x1 dose
- Epinephrine 0.3 mg IM x1 for severe reaction (may repeat x1 in 3–5 minutes for continued severe symptoms)

Other: (labs, central line care, other medications)

_____

_____

_____

PROVIDER SIGNATURE	DATE
PRINT PROVIDER NAME	*PROVIDER EMERGENCY PHONE #

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