

Hydration Infusion Referral Form



Patient Preferred Clinic (select one): **PATIENT**

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB:	Patient Name:	Patient Phone:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight (lbs/kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

☒ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

<input type="checkbox"/> CBC	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CMP	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CRP	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
OTHER _____		

IV HYDRATION THERAPY ADMINISTRATION (self pay)

1000 ml Normal Saline (\$129)

500 ml Normal Saline (\$119)

Frequency: _____

Hydration will be infused over one hour unless otherwise ordered by referring provider.

NOTES/ADDITIONAL COMMENTS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print)	Provider Signature	Date
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Have a Question? (212) 776-9090

Email Referrals To: info@specialtyinfusion.com

Fax Referrals To: (800) 540-1852

E-Prescribe: QuickRx 2nd Ave, 2355 2nd Avenue, New York NY 10035 Tel: 212-858-0659

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