Cascade ID & Infusion

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐M ☐F Weight: _____ lbs.	NPI:_____
Height:_____ICD-10 Code(s):_____	Practice:_____
Diagnosis: _____	Phone:_____
Allergies: _____	Fax:_____
Primary Care Provider:_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): _____

_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): _____

HYDRATION ORDERS & INSTRUCTIONS

☐ **NORMAL SALINE**

20 mL/kg to be given IV over 1 hour (Maximum of 2000 mL)

FREQUENCY/DURATION OF TREATMENT: _____
(This must be filled out for continued therapy OR this form will be considered a one time order.)

P dication(s):

☐ _____ (10-15 mg/kg) PO

☐ Toradol _____ (15-30 mg) IV

☐ Ondan etron/Zofran: Ô Î (5 /

☐ Decadron _____ mg IV

Quick Checklist for referring ydration patients.

□ Include demographic sheet and copy of insurance card(s).

□ Completed Cascade ID & Infusion Specialty Order Form

□ Recent Progress Note

Physician's Signature:_____ **Date:**_____

Fax completed form to **(503) 540-3105**

Questions? Call us at **(503) 540-9999**

03/22