McLeod Health

Place Sticker Here

Fluid and Electrolyte Replacement Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ ICD 10 Code: _____ Diagnosis Description: _____

Fluid Orders:

• Sodium Chloride 0.9% _____ mL infused over _____ hours for 1 dose (unless otherwise specified)

● Other: _____

Electrolyte Orders:

● Potassium Chloride infused per protocol for 1 dose	☐ 10 mEq	☐ 20 mEq	☐ 40 mEq
● Magnesium Sulfate infused per protocol for 1 dose	☐ 2 g	☐ 4 g	
● Calcium Gluconate infused per protocol for 1 dose	☐ 1 g	☐ 2 g	

● Other: _____

Lab Orders:

☐ Basic Metabolic Panel (BMP)

☐ Other: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Clarendon: 803-435-3194 (Fax)

803-435-3226 (Phone)