

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.

Dillon: 843-487-1491 (Fax)

843-487-1334 (Phone)