



## Lactated Ringers Infusion Order Form

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F

Allergies: \_\_\_\_\_

New Treatment     Continuing Treatment    Last Treatment Date: \_\_\_\_\_    Next Due Date: \_\_\_\_\_

### Diagnosis and ICD 10 Code (Required)

Other: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

Other: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

### Labs

CBC Results \_\_\_\_\_

CMP Results \_\_\_\_\_

Other: \_\_\_\_\_

### Other medications:

\_\_\_\_\_

### Nursing

Provide nursing care per Smart Infusion Nursing Procedures,  
Including reaction management and post-procedure observation.

### Special Instructions / Notes

<b>Lactated Ringers Order</b>
<u>Dosage</u>
_____ ML
Rate _____
Frequency _____
Maximum number of treatments _____
<u>Frequency</u>
<input type="checkbox"/>
<input type="checkbox"/> Other _____

<b>Required Documents</b>
<input type="checkbox"/> Patient Demographic Sheet
<input type="checkbox"/> H & P within the past 6 months
<input type="checkbox"/> Current Medication List
<input type="checkbox"/> Clinical and Progress Notes
<input type="checkbox"/> Last infusion note if applicable

<b>Location</b>
<input type="checkbox"/> Eau Claire <input type="checkbox"/> Weston <input type="checkbox"/> Middleton

### Provider Information

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_