



**MATAGORDA REGIONAL**  
 MEDICAL CENTER  
 MPMC IV THERAPY SERVICES  
 PHONE: 979-241-5966  
 FAX: 979-241-5965

**STAT REFERRAL**

**HYDRATION ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_  
 HT: \_\_\_\_\_ WT: \_\_\_\_\_ Sex : ( ) Male ( ) Female SSN: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Allergies: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
 Secondary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_

**PHYSICIAN / FACILITY INFORMATION**

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 DEA#: \_\_\_\_\_ NPI #: \_\_\_\_\_ State Lic #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE) \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
 Does patient have venous access?  YES  NO If yes, what type  MEDIPORT  PIV  PICC LINE  OTHER: \_\_\_\_\_

- a) ALLMEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
- b) ADMINISTER CATH-FLO 2MG, IVP IF PICC LINE BECOMES SLUGGISH OR OCCLUDED: MAY REPEAT AFTER 2 HRS IF NEEDED X 1.

**PRESCRIPTION ORDERS FOR HYDRATION**

Select the fluid requested AND the corresponding rate below

1.)  **NORMAL SALINE**

2.)  **LACTATED RINGERS**

<input type="checkbox"/> 500 mls, IV x	<input type="checkbox"/> 500 mls, IV x
<input type="checkbox"/> 1000 mls (1 Liter), IV x	<input type="checkbox"/> 1000 mls (1 Liter), IV x
<input type="checkbox"/> 2000 mls (2 Liters), IV x	<input type="checkbox"/> 2000 mls (2 Liters), IV x
<b>RATE</b>	<b>RATE</b>
<input type="checkbox"/> <b>BOLUS - GIVEN OVER 1 HOUR</b>	<input type="checkbox"/> <b>BOLUS - GIVEN OVER 1 HOUR</b>
<input type="checkbox"/> Over 2 hours @ _____ mls/hour	<input type="checkbox"/> Over 2 hours @ _____ mls/hour
<input type="checkbox"/> Over 4 hours @ _____ mls/hour	<input type="checkbox"/> Over 4 hours @ _____ mls/hour
<input type="checkbox"/> Other: _____ mls/hour	<input type="checkbox"/> Other: _____ mls/hour
<input type="checkbox"/> <b>OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW):</b>	

**LABS:**

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	NONE
	CBC w/ Diff	( ) PRIOR ( ) POST
	BMP	( ) PRIOR ( ) POST
	CMP	( ) PRIOR ( ) POST
	BUN/CREATININE	( ) PRIOR ( ) POST
	Other:	( ) PRIOR ( ) POST

**NOTES/INSTRUCTIONS/COMMENTS**


**FLUSHES:**  Heparin 500 units/5 mL Flush Syringe PRN

Provider's Signature \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

Fax completed form to the MPMC Infusion Center at 979-241-5965.  
 PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed. Reviewed 04/2026