BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height _____ Weight _____

Infusion Location: (state and site) _____

IV Hydration Infusion Center Orders

☐ 0.9% Sodium Chloride	☐ 0.45% Sodium Chloride	☐ Lactated Ringers
Diagnosis: ensure ICD-10 code is added		
☐ Dehydration	Other	

Dosing:

☐ _ml to infuse over ____hours

Frequency:

☐ ONCE ☐ Every _____days/weeks (please specify d/w)

Other orders:

_____

_____

☐ Ok to leave IV in for treatment on consecutive days.

Ordering Provider: (please print): _____

Reviewed 3/06/2023. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.