



# Hydration Order Form

Select patient referral location:            Anchorage            Palmer            Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.  
For new referrals, please **include recent labs and last two office visit notes.**  
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

## 1. PATIENT INFORMATION

Name:		DOB:	
Home phone:		Other phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M      F	Weight:	
Patient Status:	New to therapy	Continuing therapy	Next due date (if applicable):

## 2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State:	Zip:
Office contact:		Email:	
Office phone:		Office fax:	

## 3. DIAGNOSIS INFORMATION (and year of diagnosis)

ICD 10 ( \_\_\_\_\_ )                      Other (specify): \_\_\_\_\_

## 4. INSURANCE INFORMATION

*Please submit copies of the front and back or primary and secondary insurance cards with this referral.*

## 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

### IV SOLUTION

0.9 % Normal Saline (0.9% NaCL)

Infuse \_\_\_\_\_ ml over \_\_\_\_\_ (time) \_\_\_\_\_ (frequency)

Lactated Ringer's Solution (LR)

Infuse \_\_\_\_\_ ml over \_\_\_\_\_ (time) \_\_\_\_\_ (frequency)

Vital signs per LUX Protocol

Anaphylaxis & Hydration Management per LUX Protocol

## 6. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE