(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____

Allergies with reaction type:_____

Common IV Fluids

Version 1 2/5/14

IV Placement

☐ Peripheral IV insert/maintain

IV Fluids - Generic Volume Bolus

IV Fluid-Bolus

☐ Fluid: _____
Additive: _____
Rate: _____
Duration (If rate not selected): _____

IV Fluids - Maintenance Specific Fluid

Sodium Chloride 0.9% IV

☐ _____ milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.45% Sodium Chloride IV

☐ ____ milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.9% Sodium Chloride IV

☐ _____ milliliter/hour continuous intravenous infusion

D5-0.45% Sodium Chloride with Potassium Chloride 20 mEq/L IV (PREMIX)

☐ _____ milliliter/hour continuous intravenous infusion

sodium chloride 0.9% with potassium chloride 20 mEq/L IV (PREMIX)

☐ ____ milliliter/hour continuous intravenous infusion

IV Fluids - Maintenance Generic Fluid

- Select this fluid for IV solution not listed above

IV Fluid-Maintenance

☐ Fluid: _____
Additive: _____
Rate: _____
Duration (If rate not selected): _____

Provider Signature:_____Date:_____Time:_____