



Trinity Health Grand Haven (THGH) Infusion Clinic
 1309 Sheldon Road
 Grand Haven, MI 49417
 Phone: 616-758-4994
 Fax: 616-758-4657

CT IV Hydration

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent visit notes

Order Date: ___/___/___

Patient Name: _____

Date of Birth: ___/___/___

Weight: _____ Height: _____

Allergies: _____ NKA

Primary Insurance: _____

Member ID: _____

Secondary Insurance: _____

Member ID: _____

Authorization # _____

<p>**Patient may require hydration prior to a scan depending on Glomerular Filtration Rate (GFR) result. GFR of 30-45 will require hydration before and after the exam. GFR <30 requires signed approval from the patient's physician to administer contrast.**</p>	
<p><input type="checkbox"/> Patient is greater than 60 years of age</p> <p><input type="checkbox"/> Patient has history of renal disease or insufficiency</p> <p><input type="checkbox"/> Patient is diabetic: <input type="checkbox"/> Type I <input type="checkbox"/> Type II</p> <p><input type="checkbox"/> Patient is currently receiving chemotherapy</p> <p><input type="checkbox"/> If any of these criteria are met, please order a GFR and Creatinine test (results must be \leq30 days Prior to the CT exam)</p>	<p>GFR result _____ Creatinine result _____</p> <p>Date of most recent GFR/Creatinine: _____</p> <p>**Please attach copy of lab results if completed at different facility than THGH</p> <p>If GFR is 30-45 ml/min: Specify which Hydration:</p> <p><input type="checkbox"/> Hydrate pre & post CT with 0.45 NS 250cc pre CT and 250cc post CT</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>
<p>Provider Name: _____</p> <p>Office Phone Number: _____</p> <p>Attending Physician Name: _____</p>	<p>Provider Signature: _____</p> <p>Office Fax Number: _____</p> <p>Date: _____</p>

