Holland Hospital

AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
Fax (616) 394-2139

CT Hydration Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

Please check one of the following options:

☐ 0.9% Normal saline 250cc/hr for 2 hours prior to CT exam.
(Recommended for patients with known multiple myeloma or eGFR less than 45)

☐ 0.9% Normal saline 125cc/hr for 2 hours prior to CT exam.
(Recommended for patients with known multiple myeloma or eGFR less than 45 if congestive heart failure or risk of fluid overload)

☐ Other:

Note: Hydration may be contraindicated if acute CHF, end-stage renal failure, severe hypertension, or pre-cardiac transplant status.

Nursing Considerations: please refer to Holland Hospital policy 34.15.4 for standard protocol.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____