Trinity Health Grand Haven (THGH) Infusion Clinic
1309 Sheldon Road
Grand Haven, MI 49417
Phone: 616-847-4994
Fax: 616-844-4657

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 #_____

****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.****

❑ Patient is greater than 60 years of age ❑ Patient has history of renal disease or insufficiency ❑ Patient is diabetic: ❑ Type I ❑ Type II ❑ Patient is currently receiving chemotherapy ❑ If any of these criteria are met, please order a GFR and Creatinine test (results must be ≤30 days Prior to the CT exam)	GFR result_____ Creatinine result_____ Date of most recent GFR/Creatinine:_____ ****Please attach copy of lab results if completed at different facility than THGH** **If GFR is 30-45 ml/min: Specify which Hydration:** ☐ Hydrate pre & post CT with 0.45 NS 250cc pre CT and 250cc post CT ☐ Other_____ _____
Provider Name: _____ **Office Phone Number: _____** **Attending Physician Name: _____**	**Provider Signature: _____** **Office Fax Number: _____** **Date: _____**