<table>
<thead>
<tr>
<th>WEIGHT:</th>
<th>g</th>
<th>IV CATHETER PLACEMENT (CHECK APPROPRIATE BOX)</th>
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<tbody>
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<td>☐ CENTRAL     ☐ PERIPHERAL   ☐ UMBILICAL</td>
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</table>

**DATE __________________**  
**BOTTLE # __________**  

**DEXTROSE**  
(Standard volume = 250 ml)  

**DATE______________**  
**BOTTLE #__________**  

**Electrolytes Per 1000 ml:**  
- Sodium Chloride: __________________ mEq  
- Sodium Acetate: __________________ mEq  
- Potassium Chloride: __________________ mEq  
- Calcium Gluconate: __________________ mEq  

(Na to be 0-150 mEq)  
(K to be 0-50 mEq)  
(Calcium Gluconate to be 0-64 mEq)  

**Heparin 1 Unit/ml**  
Yes ☐ No ☐  

**Other Additives:**  

**Comments:**  

**Infusion Rate**  
________________ ml / hour  

**RN Signature**  

**Note:** These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated, timed and signed below.

**Date** __________  **Time** __________  **Physician’s Signature** __________  

Another brand of drug, identical in form and content, may be dispensed unless checked. ☐