Hydration Orders for Iodinated Contrast Procedures

Van Wert County Hospital

1) Patients at risk for nephrotoxicity with iodinated contrast include:
   a) Age 65 years or older
   b) History of kidney disease (including surgery, renal tumor, solitary kidney, or renal transplant)
   c) Family history of kidney disease
   d) Myeloma
   e) Liver disease
   f) Diabetes
   g) Potentially nephrotoxic medications (i.e. metformin, chemotherapy, long-term NSAID use, aminoglycosides, etc.)

2) Draw serum BUN and creatinine for patients at risk for nephrotoxicity with iodinated contrast.
   • Outpatients with normal values (BUN ≤ 18 mg/dL and creatinine ≤ 1.1 mg/dL) within 2 months or abnormal values within 10 days may be used
   • Inpatients may use values within 72 hours

   BUN/Serum creatinine (with date/time drawn):______________________________

   Patient Weight: ___________ kg

3) Contact radiologist for hydration recommendations prior to iodinated contrast studies. Hydration should be customized on an individual basis (i.e. patient with congestive heart failure, etc.)
   • Please check appropriate box(es)
   □ Acetylcysteine (Mucomyst) 600 mg PO twice daily the day before the procedure and the day of the procedure.

   Outpatients:
   □ Normal Saline as a bolus at 3 mL/kg/hour x 1 hour prior to the procedure. Following the procedure, if the patient has no signs or symptoms of fluid overload, administer a second bolus of the same fluid at 3 mL/kg/hr x 1 additional hour.
   □ Oral Hydration – 32 oz fluid(non-alcoholic) ingested within 1 hour prior to study. 32 oz fluid(non-alcoholic) following study and encouraged to increase fluid intake for 12 hours after study.
   □ Other: __________________________________________________________

   Inpatients: (Please check appropriate box)
   □ Normal Saline as a bolus at 3 mL/kg/hour x 1 hour prior to procedure. Following the procedure, if the patient has no signs or symptoms of fluid overload, administer a second bolus of the same fluid at 1.5 mL/kg/hr x 3 more hours.
   □ Other: __________________________________________________________

PHYSICIAN SIGNATURE: ___________________________ Date / Time: ________________