Hydration, Electrolytes, Anti-Emetics

Order Form
Rev. 10/19/2023

Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

□ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ○ Yes *(please fax IA a copy)* ○ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

LAB ORDERS

Collect: □ BMP □ CMP □ CBC w/o Diff □ Magnesium □ __________

Lab Frequency: ○ ONCE at first infusion ○ Every infusion ○ __________________

THERAPY ADMINISTRATION

○ Infusion Associates provider to select fluid based on compatibility, **OR**

IV Hydration:

- □ 0.9% Sodium Chloride
- □ Dextrose 5% with 0.9% Sodium Chloride
- □ Dextrose 5% with Lactated Ringers
- □ Lactated Ringers
- □ 0.9% Sodium Chloride with **20meq Potassium Chloride** (in 1000mL)

Volume to be infused at each visit:
- □ 1000 mL
- □ 2000 mL
- □ ________ mL

IV Medications/Additives | Please select total dose to be given at each visit:

- □ None
- □ Folic Acid ________ mg
- □ Thiamine ________ mg
- □ Magnesium Sulfate ________ gm
- □ Dexamethasone ________ mg
- □ Other: ______________________________

Anti-Emetics
- □ Metoclopramide (Reglan) ________ mg
- □ Ondansetron (Zofran) ________ mg
- □ Promethazine (Phenergan) ________ mg
- □ Prochlorperazine (Compazine) ________ mg

Frequency: ○ One infusion ○ Daily for ________ days ○ _______-________ times a week ○ Every other day ○ Weekly ○ PRN ○ _________________

Injections: ○ Vitamin B12 *(cyanocobalamin)* 1000mcg IM
Frequency: __________________ Number of doses: ________________

Date of last infusion if not at IA: ____________ RX Expiration Date: ____________

Additional Notes from Referring Office:

______________________	______________________	______________
Provider Name (Print)	**Provider Signature**	**Date**