*Patient Insurance & ID (front and back) are needed

HYDRATION

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx: Patient Name: | Patient Weight: KG | DOB:

Fluid:

☐ Normal Saline ☐ D5 1/2 NS ☐ 1/2 Normal Saline ☐ D5LR ☐ D5NS ☐ Lactated Ringers

☐ Other: _____

Volume:

☐ 1 Liter (1000mL)
☐ 2 Liter (2000mL)
☐ 500mL
☐ Other: _____

Frequency:

☐ One time dose _____
☐ _____ times per week
☐ Other: _____

Rate of Administration:

☐ Bolus, as tolerated
☐ Over 1 hour
☐ Over 2 hours
☐ Over _____hours

Additional IV additive medications for infusion:

☐ **MVI** ☐ **Mag sulfate IV:** ☐ 1gm ☐ 2gm ☐ Other:

Additional medications for IVP:

Zofran IVP: ☐ 4mg ☐ 8mg **Reglan IV:** ☐ 10mg **Pepcid IVP:** ☐ 20mg **Protonix IVP:** ☐ 40mg

Regimen duration (if > than one time dose): ☐ 1 week ☐ 30 days ☐ 3 months ☐ 6 months

☐ Other: _____ ☐ PRN until, date: _____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg
☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO
☐ Others:

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis:
ICD-10 Code:

OTHERS (Dx + ICD Code 10):

N P I #:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:
Fax:
Email:
Other:

Office Mailing Address:

Please include the following

☐ Patient demographics & Insurance attached
☐ Diagnosis (supporting)
☐ History and Physical
☐ Lab Results
☐ Clinical progress notes
☐ Medication List
☐ Other Test Results
☐ Mag Level (Mag)
☐ Potassium Level (KCL infusion)