Intralipid Order

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information: ❒ **Demographics** ❒ **Progress notes**

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

INTRALIPIDS 20%

Date of Last Treatment, If Continuation:

_____ **mL in** _____ **mL of Normal Saline, to be given over** _____ **hrs**

Frequency and Duration: _____

Start Date of Infusion: _____ End Date of Infusion: _____

Other Orders or Special Instructions: