FLX Medical Infusion

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IV Infusion Medication ORDER form

This acts as a prescription and MUST be signed by the ordering Physician

Drug and Directions:(include dose route and frequency)

_____

Pre-medications

[ ] Diphenhydramine 50MG IV 30-60min prior

[ ] Acetaminophen 650MG PO 30-60min prior

[ ] Methylprednisone 100MG IV 30-60min prior

[ ] Sodium Chloride 0.9% IV 250mL 500mL (Hydration) 30-60min prior

[ ] Allegra 180mg PO 30-60min prior

Post-medications

[ ] Diphenhydramine 25MG PO as needed for itching or rash

[ ] Acetaminophen 650MG PO may repeat every 4-6 hours as needed not to exceed 4000mg/day

[ ] Sodium Chloride 0.9% IV 250mL 500mL (Hydration)

PRN Emergency Orders

[ ] Diphenhydramine 50MG IV x1 PRN for itching hives rash flushing

[ ] Sodium Chloride 0.9% IV 500mL x1 PRN for hypotension

[ ] Epinephrine 1:1000, 0.3mL (>30kg/>66lbs) PRN Severe allergic reaction

***Prescriber Signature: _____ Date: ***

PRESCRIBERS INFORMATION:

Prescriber's Name:_____ NPI #_____

Phone: _____ Fax: _____ Office Contact:_____

PATIENT INFORMATION:(Complete or include demographic sheet)

Patient Name: _____ DOB:_____

Address: _____

Phone: _____ Email: _____

Emergency Contact Name:_____ Relationship:_____

Phone: _____

PATIENT INSURANCE INFORMATION:(Complete or include a copy of the ID card)

Insurance Company _____ ID_____

Group_____BIN_____PCN_____

PATIENT DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis (ICD-10 Code):_____Description:_____

Height _____ Weight _____ Allergies _____