AYSA
THERAPEUTICS INFUSION

IV FLUID ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ____________ Phone: ________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION HISTORY

☐ Congestive Heart Failure - Ejection Fraction % ______________________

☐ Renal Impairment ☐ Other Cardiac History: ____________ ☐ Diabetes ☐ Other History: ____________

DIAGNOSIS - (ICD-10)

☐ Dehydration __________ ☐ Gastroenteritis __________ ☐ Nausea / Vomiting __________

☐ Electrolyte Imbalance __________ ☐ Hyperemesis of Pregnancy __________ ☐ Other: __________

FLUID

☐ Normal Saline ☐ D5 .45NS - (D5 - .45 Normal Saline) ☐ .45 Normal Saline ☐ D5 Lactated Ringers

☐ D5NS - (D5 Normal Saline) ☐ Lactated Ringers ☐ Other: ______________________

VOLUME	FREQUENCY	RATE OF ADMINISTRATION
☐ 1 Liter (1000mL)	☐ One time dose ________	☐ Bolus, as tolerated
☐ 2 Liter (2000mL)	☐ ________ times per week	☐ Over 1 hour
☐ Other: __________	☐ Other: __________	☐ Over 2 hours
		☐ Over ________ hours

ADDITIONAL IV MEDICATIONS

Zofran IVP: ☐ 4mg ☐ 8mg **Reglan IV:** ☐ 10mg - 100mL NS **Pepcid IV:** ☐ 20mg IV **KCL:** ☐ 20Eq in 1000mL NS

Protonix IV: ☐ 40mg **MVI (infuvite):** ☐ 1 AMP in 1000mL NS

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

☐ Clinical/Progress Notes, Labs, Test supporting primary diagnosis

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ________________ Physician Name: ________________ Date: ________

Phone: ________________ Fax: ________________ Contact Person: ________________

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