PARAGON
INFUSION CENTERS

IV FLUID
INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

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

HISTORY

☐ Congestive Heart Failure - Ejection Fraction % _____

☐ Renal Impariment ☐ Other Cardiac History: _____ ☐ Diabetes ☐ Other History: _____

DIAGNOSIS - (ICD-10)

☐ Dehydration _____ ☐ Gastroenteritis _____ ☐ Nausea / Vomiting _____

☐ Electrolyte Imbalance _____ ☐ Hypermesis 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

☐ 1 Liter (1000mL)

☐ 2 Liter (2000mL)

☐ 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 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 Paragon Healthcare, 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: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566
Fax: 855-889-2946

Texas
☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills
☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak

Tennessee
☐ Knoxville

Georgia
☐ Atlanta

PARAGONHEALTHCARE.COM