OKLAHOMA INFUSION SERVICES

IV Fluid Order Form

Please fax form back to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	**Email:**	**Insurance:**	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ E86.0 Dehydration
☐ K52.29 Other Allergic and Dietetic Gastroenteritis and Colitis
☐ R11.2 Nausea with Vomiting, Unspecified
☐ E87.8 Electrolyte and Fluid Imbalance
☐ O21.0 Mild Hyperemesis Gravidarum

☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Other _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Zofran IV	Dose: ☐ 4mg ☐ 8mg	Frequency: ☐ every _____
☐ Reglan IV	Dose: ☐ 10mg	Frequency: ☐ every _____
☐ Pepcid IV	Dose: ☐ 20mg	Frequency: ☐ every _____
☐ Protonix IV	Dose: ☐ 40mg	Frequency: ☐ every _____
☐ Other	Medication: _____ ☐ Dose: _____	Frequency: ☐ every _____

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☒ Tylenol tablet 500-1000mg PO PRN
☒ Benadryl 25mg PO PRN
☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	**DEA #:**	**Contact Phone:**	**Contact Fax:**

_____ _____
Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form back to: 405-726-9849

Edmond
1701 Renaissance Blvd, Ste 110
Edmond, OK 73013
Phone: (405) 844-4978

Enid
825 E Owen K Garriott Rd
Enid, OK 73701
Phone: (580) 701-2586

Tulsa
6135 S 90th E Ave
Tulsa, OK 74133
Phone: (539) 215-5609

www.okinfusion.com