



IV TREATMENT FORM

Please fax the completed form to 1-877-384-2278

PATIENT DETAILS			
Name		Date Of Birth (DD/MM/YYYY)	
Email		Phone	
Address		Health Card Number	
Emergency Contact Name		Emergency Contact Number	

CLINICAL DETAILS			
Diagnosis/Indication:		Renal Function (if required for dosing):	Creatinine: _____
<input type="checkbox"/> Dehydration <input type="checkbox"/> Fatigue/Low Energy <input type="checkbox"/> Pre/Post-Surgery Support <input type="checkbox"/> Medication Administration		Allergies (esp. Penicillin, Cephalosporins, Sulfam):	
		Previous Reactions to IV Antibiotics: (If yes, then specify)	<input type="checkbox"/> Yes, specify: <input type="checkbox"/> No
		Relevant Medical History:	
		Has patient received any IV products previously:	

MEDICATION ORDER DETAILS			
Medication	Dilution	Route	Frequency
Name of IV Fluid/Medication: _____ Dose: _____ mg Therapy Length: _____ days Total Number of Infusions Prescribed: _____	Dilution: _____ (if needed)	<input type="checkbox"/> IV PUSH <input type="checkbox"/> IV Infusion Duration: _____ minutes	<input type="checkbox"/> Once <input type="checkbox"/> Daily <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID Other: _____

OTHER MEDICATIONS		
If the patient has a HISTORY of reaction to any IV Medication/fluids the following medication IMMEDIATELY prior to the infusion: <input type="checkbox"/> Methylprednisolone 125mg IV x1 <input type="checkbox"/> Diphenhydramine 25-50 mg PO/IV <input type="checkbox"/> Acetaminophen 650 mg PO Other: _____	<input type="checkbox"/> Our clinics follow a standardized protocol to manage reactions during our post-infusion. Tick this box to indicate that you agree with the following protocol. If the patient has adverse reaction DURING/POST infusion, give: <input type="checkbox"/> Hydrocortisone 100mg IV <input type="checkbox"/> Methylprednisolone 125mg IV <input type="checkbox"/> Diphenhydramine 25-50mg PO/IV <input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Dimenhydrinate Gravol® 25-50mg PO/IV	Current infusion reaction protocol includes the use of these medications according to nurse's assessment.

PRESCRIBER DETAILS					
CareMed will handle special authorization forms and apply an infusion fee at CareMed. Patients receive a receipt for tax or health account purposes. Patients will be scheduled at CareMed within 7 days of payment. Prescribers will be notified if the patient cannot be reached. Post-infusion reports are provided. For Hospital Day Medicine appointments, patients receive home-delivered drugs to bring to their appointment. Bloodwork may be updated to meet clinical standards.					
Address		Phone		Fax	
Prescriber Name		License Number			
Prescriber Signature		Date (DD/MM/YYYY)			

