HILL COUNTRY
Infusions

INFUSION ORDERS

Patient name: _____ **Date of Birth:** _____

Current medications/Supplements:

_____

_____

_____

Known allergies or sensitivities to any vitamins or supplements (list): _____

Are you Pregnant or breastfeeding? ☐ Yes ☐ No

Significant medical conditions (circle): Asthma Cardiac Arrhythmias Clotting Disorder Congestive Heart Failure Diabetes Diarrhea G6PD deficiency Hemochromatosis High/Low Blood pressure Hypo/Hyperthyroidism Liver or Kidney Disease Multiple Sclerosis Peripheral edema Peripheral neuropathy Sarcoidosis Seizure disorders Sickle cell Anemia Systemic Lupus Erythematosus

Notes:_____

Exam: Contraindications to treatment? _____

Assessment: allergies asthma chronic sinus infections migraines chronic fatigue decreased energy decreased libido depression diabetes fibromyalgia hypertension hyperlipidemia muscle spasms/pain upper respiratory tract infection other :_____

Plan: Patient to receive below treatment. Risks, benefits and options for treatment (including no treatment) discussed and all questions answered. A full history has been reviewed an assessment of patient's current health status and needs have been performed.

No contraindications have been found for the following treatment with:

- ☐ Myers infusion
- ☐ Energy Infusion
- ☐ Hangover Help Infusion
- ☐ Marathon Infusion
- ☐ Immune Boost Infusion
- ☐ High Energy Infusion
- ☐ Premium Infusion
- ☐ Ondansetron
- ☐ Diphenhydramine
- ☐ Ketorolac

_____ _____

MD Signature Nurse Signature

_____

Date