INFUSION ORDERS

Patient Name: ________________________________ **Date of Birth:** ____________________ **Date:** ____________________

Current Medications/Supplements:

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Medication Allergies: ____

Known allergies or sensitivities to any vitamins, supplements, or latex (*list*): ____

Pregnant or Breastfeeding? ☐ Yes ☐ No

Significant Medical Conditions (*circle*): Asthma Cardiac Arrhythmias Cancer Chronic Infections Clotting Disorder Congestive Heart Failure Diabetes Diarrhea 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 G6PD deficiency

Other:____

Pre-infusion vital signs:

BP: __________ **HR**: _________ **Temp**: ________ **RR**: ________ **SpO2**: _________ **Ht:** _________ **Wt:** _________

<u>To Be Filled Out by Provider:</u>

Exam: Contraindications to treatment? ☐ Yes ☐ No

Additional Notes: ____

Assessment: allergies asthma chronic sinus infections migraines chronic fatigue decreased energy decreased libido depression anxiety dehydration diabetes fibromyalgia hypertension hyperlipidemia muscle pain/inflammation upper respiratory tract infection nausea/vomiting 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
- ☐ Glutathione

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Provider Signature

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Nurse Signature