OKLAHOMA INFUSION SERVICES

IV Fluid Order Form

Please fax form 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 ☐ E87.8 Electrolyte and Fluid Imbalance

☐ K52.29 Other Allergic and Dietetic Gastroenteritis and Colitis ☐ O21.0 Mild Hyperemesis Gravidarum

☐ R11.2 Nausea with Vomiting, Unspecified

☐ 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	Lab Orders to be done by
☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Other: _____	☐ Oklahoma Infusion Services

Prescription Information

☐ 0.9% Normal Saline	☐ 500 mL ☐ 1000 mL ☐ Given over _____ hours ☐ Frequency: _____
☐ Lactated Ringer	☐ 500 mL ☐ 1000 mL ☐ Given over _____ hours ☐ Frequency: _____
☐ Zofran IV	Dose: ☐ 4mg ☐ 8mg ☐ Frequency: every _____
☐ Reglan IV	Dose: ☐ 10mg ☐ Frequency: every _____
☐ Pepcid IV	Dose: ☐ 20mg ☐ Frequency: every _____

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.

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