Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

IV medication ORDERS

Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: ***ICD-10*** : **_____, _____, _____**

LABS to be drawn:

- ☐ **NONE**
- ☐ CBC
- ☐ PT, PTT
- ☐ BMP
- ☐ CMP
- ☐ CK/CPK
- ☐ Urinalysis
- ☐ Other: _____

Frequency:

- ☐ Weekly
- ☐ Monthly
- ☐ Daily
- ☐ Other: _____

IV medication order:

Medication Name:_____

Dose:_____

Frequency and Duration: _____

Start Date of Infusion: _____/_____/_____ **End Date of Infusion**: _____/_____/_____

Other Orders: _____

Printed Provider's Name: _____

Provider's Signature: _____

Office Phone Number: _____ **Fax Number:** _____