LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

Infusion Therapy Orders

Diagnosis (please provide ICD-10 code *and* description):

_____ _____ _____ _____

(ICD-10) (description) (ICD-10) (description)

Orders

(please include drug, dose, route, frequency, volume/concentration and infusion rate as applicable):

- If adverse reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.