



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- | | |
|---|---|
| ☐ A08.4 Viral Gastroenteritis | ☐ G90.A Postural Orthostatic Tachycardia Syndrome (POTS) |
| ☐ E86.0 Dehydration | ☐ O21.1 Hyperemesis Gravidarum |
| ☐ E83.42 Hypomagnesemia (must submit supporting lab results) | ☐ Q79.60 Ehlers-Danlos Syndrome |
| ☐ E87.6 Hypokalemia (must submit supporting lab results) | ☐ Other: _____ |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

- | | |
|--|--|
| ☐ Acetaminophen: 650 mg PO | ☐ Acetaminophen: _____ mg PO |
| ☐ Cetirizine 10 mg PO | ☐ Famotidine: _____ mg IV |
| ☐ Dexamethasone: _____ mg IV | ☐ Loratadine 10 mg PO |
| ☐ Diphenhydramine: 25 mg PO | ☐ Methylprednisolone: _____ mg IV |
| ☐ Diphenhydramine: 25 mg IV | ☐ Ondansetron 4 mg IV |
| ☐ Prochlorperazine (Compazine): _____ mg IV | |

Lab Orders

- ☐ CBC w/diff: every _____ ☐ weeks ☐ month
☐ CMP: every _____ ☐ weeks ☐ month
☐ Other: _____ ☐ weeks ☐ month

Hydrations

- ☐ IV: infuse 1L NS _____ x per week PRN for one year
☐ IV: infuse 2L NS _____ x per week PRN for one year
☐ IV: infuse 1L LR _____ x per week PRN for one year
☐ IV: infuse 2L LR _____ x per week PRN for one year
☐ Other: _____

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**** OSI does not currently infuse vitamin bags ****

**** OSI does offer Magnesium Sulfate and Potassium Chloride replacement (please provide parameters when to give or to hold when ordering)**

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose: _____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI # _____ Specialty: _____

Office phone #: _____ Office Fax #: _____