Oncology for IV/IM Therapy

To: Infuzed IV Hydration & Wellness — From: Oncology Provider

Client Name: ____
Address: ____
Age:_______________Sex ___________________ Date of Birth: __________________________

Your patient is requesting a service offered by Infuzed IV Hydration & Wellness. Because of your client's diagnosis/health history, we ask Infuzed IV clients to discuss this with their physician and have their physician sign off on the treatments listed below. We require this to keep clients safe and to ensure they do not have underlying pathology that can affect delivery of services.

Provider: Please indicate what Infuzed services client may receive.

- Ondansetron 4mg IV- Indicate frequency: _________________________________
- Ketorolac 30mg IV/IM once weekly for pain
  Indicate other frequency:____
- IV Fluids (We allow 1-2 L a week for healthy individuals) Indicate other volume limits:
  Prefer Lactated Ringers _____________Prefer Normal Saine _____________
- Intravenous (IV) Vitamin Micronutrient Administration (see list below)
- Intramuscular (IM) Vitamin Micronutrient Administration (list below)
- IV Infusion rate with vitamin micronutrient administration. Typical infusion is 1L NS or LR over 60-90 minutes with IV micronutrients added one by one.

Provider: Response

- No contraindications for IV Therapy
- No special precautions for IV/IM Therapy

Micronutrient list (subject to change) Ascorbic Acid, B-5, B-6, B12, B-Complex, BCAA, Biotin, ALA, Calcium Chloride, Multi-trace minerals, Selenium, Glutathione, L-Glutamine, L-Carnitine, Lipo, Lipo-C, EDTA, Magnesium sulfate, L-Proline, L-Lysine, Taurine, coQ10, Vitamin D3

Other notes and considerations if any: ____

Provider Name: ____
Provider License State/Number (must be licensed state Infuzed is administering) ___________________________
Provider Signature ____ Date: ______________________________