



TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-9787
Fx: 972-787-1492

IV INFUSION ORDER FORM

PATIENT INFORMATION

Name:	DOB:
Allergies:	Weight: _____ kg ; Height: _____ in

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Dx: _____ ICD 10 Code: _____
<input type="checkbox"/> Dx: _____ ICD 10 Code: _____

PRE MEDICATION

<input type="checkbox"/> Diphenhydramine PO 25-50mg 30 min before inf	<input type="checkbox"/> IV SoluMedrol 125mg slow IVP 5 min prior to infusion
<input type="checkbox"/> Acetaminophen PO 650g 30 min before infusion	<input type="checkbox"/> IV Diphenhydramine 50mg slow IVP 5 min prior to infusion
<input type="checkbox"/> IV 0.9% Sod Chl 1,000mL pre or post infusion PRN	<input type="checkbox"/> IV Prochlorperazine 5mg slow IVP 5 min prior to infusion
<input type="checkbox"/> IV 5% dextrose in water 500mL pre or post Inf	<input type="checkbox"/> IV Ondansetron 8mg slow IVP 5 min prior to infusion

MEDICATION ORDERS

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Nursing Orders: Start/ Pause/ Discontinue Peripheral or central IV line, Flush with 10-20mL Saline Flush (If Central line, add Heparin 500u/5ml as FINAL flush as needed. Pharmacy to dispense DME pump as needed to infuse.

Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)

Refills: X 1 year _____ doses

PRESCRIBER INFORMATION

Prescriber Name:	NPI:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 12-28-2023