MUNSON HEALTHCARE

Form 12519 09/23

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.

Frequency (Required):

Expiration:_____ (Max of 12 months)

Treatment Start Date:

Diagnosis (Required):	ICD-10 Code (Required):	Allergies/Reactions:

First Solution Bag	**IV Solution:** ☐ Sodium Chloride 0.9% ☐ Dextrose 5%- Sodium Chloride 0.9% ☐ Dextrose 5%- Sodium Chloride 0.45% ☐ Dextrose 5%- Lactated Ringers ☐ Lactated Ringers	**Volume to be Infused:** ☐ 500 mL ☐ 1000 mL ☐ 2000 mL ☐ Other_____	**Rate of Administration:** ☐ Over 1 hour ☐ Over 2 hours ☐ Other_____
Second Solution Bag	**IV Solution:** ☐ Sodium Chloride 0.9% ☐ Dextrose 5%- Sodium Chloride 0.9% ☐ Dextrose 5%- Sodium Chloride 0.45% ☐ Dextrose 5%- Lactated Ringers ☐ Lactated Ringers	**Volume to be Infused:** ☐ 500 mL ☐ 1000 mL ☐ 2000 mL ☐ Other_____	**Rate of Administration:** ☐ Over 1 hour ☐ Over 2 hours ☐ Other_____

Additives

Other Additive:

☐ Multiple Vitamins 10 mL

☐ Folic Acid _____mg

☐ Thiamine _____ mg

Product will be added to compatible IV solution

☐ Ondansetron _____mg IV PUSH *(will be given IVPB if dose is greater than 8 mg)*

☐ Other _____

☐ Other _____

IF PATIENT HAS A HYPERSENSITIVITY REACTION, BEGIN HYPERSENSITIVITY INFUSION REACTION PROTOCOL

Discontinue IV upon completion of treatment, flush order per protocol.

THE PHYSICIAN'S FULL SIGNATURE(S) IS TO FOLLOW THE ORDER

Patient Name:_____

Date of Birth: _____/_____/_____

_____

PROVIDER SIGNATURE **DATE** **TIME**

PRINTED NAME: _____