HYDRATION REFERRAL

vitalityinfusionsinc@gmail.com | (587) 288-6658

1 CLIENT INFORMATION

First Name * | **Last Name** * | **Date of Birth** *

DD/MMM/YYYY

Address | **Phone Number** * | **Health Card Number** *

2 MEDICAL HISTORY

Primary Diagnosis / Indication for Hydration *

Past Medical History * | **Current Medications** *

Allergies *

Pregnant * ○ No ○ Yes

Gestational Age (weeks): #

3 HYDRATION ORDER DETAILS

Normal Saline 0.9%

Volume: ☐ 500 mL / 30 min ☐ 1000 mL / 60 min

Frequency: ☐ Once ☐ # times/week for # weeks

☐ Custom frequency: Specify custom frequency

Medication Order (if applicable):

☐ Ondansetron 4mg	☐ IM	☐ IV
☐ Vitamin B6 100mg		☐ IM
☐ Vitamin B12 1000 mcg		☐ IM

Other: *Other medications require prior authorization*

Medication | Dose | Route

Medication Frequency:

☐ Once

☐ # times/week for # weeks

☐ Custom:

Specify frequency

PRESCRIPTION STATUS

☐ ✓ **Ondansetron prescription sent to pharmacy – Client must obtain before appointment with Vitality Infusions** *

4 EMERGENCY REACTION ORDER

EMERGENCY MEDICATION ORDER

☐ **Check box to agree with reaction protocols** *

Diphenhydramine 50mg IM/IV Allergic reactions	**Epinephrine 0.3mg IM** Anaphylaxis/severe reactions

5 HEALTHCARE PROVIDER INFORMATION

Name & Designation * | **PRAC ID** *

Clinic Name | **Clinic Address**

Phone * | **Fax** | **Email**

Signature *

Date *

DD/MMM/YYYY

Clear Signature

Submission Checklist:

- ☐ All required fields completed
- ☐ Prescription sent to pharmacy
- ☐ Emergency medications authorized
- ☐ Provider signature completed

Vitality Infusions Inc.

Submit to: vitalityinfusionsinc@gmail.com | (587) 288-6658