Phone and Fax: 608-690-7210
www.MySmartInfusion.com

0.9 Normal Saline

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Other: _____ ICD 10 Code: _____

☐ Other: _____ ICD 10 Code: _____

Labs

CBC Results _____

CMP Results _____

Other: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

0.9 Normal Saline Order

Dosage

_____ML

Rate_____

Frequency_____

Maximum number of treatments_____

Frequency

☐

☐ Other _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical and Progress Notes
☐ Last infusion note if applicable

Location

☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____