



**HYDRATION
INFUSION ORDERS**
P: 331-236-0610 | F: 331-314-8989

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 331-314-8989

PatientName: _____ DOB: _____ Phone: _____

PatientStatus: ☐ NewtoTherapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis:

- ☐ Dehydration ☐ Gastroenteritis ☐ Nausea/Vomiting ☐ Electrolyte Imbalance
☐ Hyperemesis of Pregnancy ☐ POTS ☐ Other: _____

ICD-10 Code _____ **Patient weight:** _____ lbs

THERAPY ORDER

Fluid:

- ☐ Normal Saline ☐ D5 1/2 NS ☐ 1/2 Normal Saline ☐ D5LR ☐ D5NS ☐ Lactated Ringers
☐ Other: _____

Volume:

- ☐ 1 Liter(1000mL)
☐ 2 Liter(2000mL)
☐ 500mL
☐ Other: _____

Frequency:

- ☐ One timedose _____
☐ _____ times per week
☐ Other: _____

Rate of Administration:

- ☐ Bolus, as tolerated
☐ Over 1 hour
☐ Over 2 hours
☐ Over _____ hours

Additional IV additive medications for infusion:

- ☐ MVI ☐ Mag sulfateIV : ☐ 1 gm ☐ 2 gm Other: _____

KCL IV: ☐ 20 meq IV ☐ 40 meq (infuse each 10meq over 1 hour)

Additional medications:

Zofran: ☐ 4mg IVP ☐ 8mg IV **Reglan:** ☐ 10mg IV **Pepcid:** ☐ 20mg IVP **Protonix:** ☐ 40mg IVP
Regimen duration (if > than one time dose): ☐ 1 week ☐ 30 days ☐ 3 months ☐ 6 months

☐ Other: _____ ☐ PRN until, date: _____

Lab Orders: _____ Frequency: ☐ Onetime ☐ Weekly ☐ Other: _____

Required labsto bedrawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing LIVbetter Infusions, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of LIVbetter selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

LIVbetter Infusions

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patients@livbetter.care

255 Town Square, Wheaton, IL 60189



COMPREHENSIVE SUPPORT FOR IV FLUID THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Labs attached
 - ☐ Serum potassium (if order contains KCL)
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ Other medical necessity: _____

LIVbetter Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to F: 331-314-8989 or call 331-236-0610 for assistance

LIVbetter Infusions

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