# Hyperemesis Gravidarum Infusion Order

Provider Order Form Rev. 7.2025

Please fax completed referral form & all required documents to 208-595-4427

INFUSED HEALTH
MEDICAL • KETAMINE • HYDRATION
IV THERAPY

## PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/State/Zip: _____

Weeks Gestation: _____ Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

## DIAGNOSIS

*ICD 10 Code Required

☐ Mild Hyperemesis Gravidarum, ICD10—O21.0

☐ Other vomiting complicating pregnancy, ICD10—O21.8

☐ _____, ICD10_____

## INFUSION ORDERS

Fluid: must check one.

☐ LR 1000 mL: Infuse _____ mL every _____ PRN _____.

☐ NS 500 mL: Infuse _____ mL every _____ PRN _____.

☐ NS 1000 mL: Infuse _____ mL every _____ PRN _____.

PRN Meds: one administration per visit unless otherwise noted.

☐ Ondansetron 4 mg ☐ IV push ☐ IM

☐ Ondansetron 8 mg ☐ IV push ☐ IM

☐ Promethazine 12.5 mg ☐ IV push ☐ IM

☐ Promethazine 25 mg ☐ IV push ☐ IM

☐ Diphenhydramine 25 mg ☐ IV push ☐ IM

☐ Diphenhydramine 50 mg ☐ IV push ☐ IM

Additives: self-pay.

☐ B6 (Pyridoxine) 25mg

☐ B1 (Thiamine) 100 mL

☐ Folic Acid 1 mg

☐ Folic Acid 0.6 mg

☐ Methylcobalamin 5 mg IV push

☐ Myer's Cocktail 10 mL

☐ Vitamin D3 (50,000 IU) 1cc IM

Is patient currently receiving therapy above from another facility? NO YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Shoudl Be Sent: _____

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**