Provider Order Form

MAGNESIUM SULFATE

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ______________

Mobile Phone: ______________________ Weight: ______ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ________ Next Treatment Date: __________

DIAGNOSIS ICD-10 code (must be specified)

☐ Hypomagnesium E83.42: ______________________ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Magnesium Sulfate, IV	☐ ________ gms	☐ Once

Other: ______________________

Refills ☐ Zero ☐ 12 months ☐ ____________ Order valid for 1 year unless otherwise stated. ________________

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every ______________
☐ CMP	☐ at each dose	☐ every ______________
☐ CRP	☐ at each dose	☐ every ______________
☐ Other ____________________	☐ at each dose	☐ every ______________

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT’S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX

______________________ Provider Signature

______________________ Date