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 in water, 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 _____