

Date: [Insert Date]

To: [Facility Name / Surgical Center]

Department: [e.g., Pediatric Outpatient Surgery]

Address: [Insert Address]

Subject: Pediatric Weight-Based Dosage Authorization

Patient Information:

Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Current Weight: [Weight in kg/lbs] as of [Date Measured]

To Whom It May Concern,

I, Dr. [Physician Name], hereby authorize the administration of medications for the outpatient procedure [Name of Procedure] scheduled on [Date of Procedure].

Based on the patient's current weight of [Weight] kg, the authorized weight-based dosages are as follows:

- **Medication 1:** [Name] - [Dosage mg/kg] - Total Dose: [Amount]
- **Medication 2:** [Name] - [Dosage mg/kg] - Total Dose: [Amount]
- **Medication 3:** [Name] - [Dosage mg/kg] - Total Dose: [Amount]

Please ensure that the patient's weight is verified upon arrival. If there is a variance of more than [Percentage]% from the weight listed above, please contact my office for a revised dosage calculation prior to administration.

Special Instructions/Allergies: [List any allergies or specific contraindications].

If you have any questions regarding these orders, please contact me at [Phone Number].

Sincerely,

[Signature]

[Physician Printed Name]

[Title/Medical License Number]

[Clinic/Hospital Name]