INTRAVENOUS THERAPY MEDICATION ADMINISTRATION AUTHORIZATION

Date: [Date]

PATIENT INFORMATION:
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Medical Record Number: [ID Number, if applicable]

PRESCRIBING PHYSICIAN INFORMATION:
Name: [Physician Full Name]
License Number: [License Number]
Clinic/Hospital Name: [Facility Name]
Phone Number: [Phone Number]

MEDICATION ORDERS:

Medication Name: [Drug Name]
Dosage: [e.g., 500mg]
Diluent/Solution: [e.g., 0.9% Normal Saline, 250ml]
Route: Intravenous (IV)
Rate of Administration: [e.g., over 60 minutes]
Frequency: [e.g., Once daily / Every 12 hours]
Duration of Treatment: [e.g., 7 days / Ongoing]

AUTHORIZATION STATEMENT:

I, Dr. [Physician Last Name], hereby authorize the clinical staff or home health nursing team to administer the above-listed intravenous medication to [Patient Name]. This authorization includes the insertion and maintenance of peripheral IV access or the use of existing central venous access devices (PICC, Port, etc.) as required for the treatment.

EMERGENCY PROTOCOL:

In the event of an adverse reaction or anaphylaxis, staff are authorized to initiate emergency protocols, including the administration of [Emergency Meds, e.g., Epinephrine/Diphenhydramine] and contacting emergency services (911).

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Physician Signature

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Date Signed

PATIENT CONSENT:

I consent to receive the intravenous therapy as prescribed above and understand the risks and benefits associated with this treatment.

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Patient / Legal Guardian Signature