Date: [Insert Date]

To: [Recipient Name/Medical Facility]
Address: [Recipient Address]
Phone: [Recipient Phone Number]

Subject: Authorization for Intravenous (IV) Therapy Administration

Dear [Recipient Name or Medical Director],

This letter serves as a formal order and authorization for the administration of Intravenous (IV) Therapy for the patient identified below:

- **Patient Name:** [Patient Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Patient ID/Medical Record Number:** [ID Number]

Treatment Specifications:

- **Diagnosis/Indication:** [Reason for Therapy]
- **IV Solution/Medication:** [Type of Fluid/Medication Name]
- **Dosage/Concentration:** [Specify Dose]
- **Rate of Administration:** [e.g., 125ml/hr or Bolus]
- **Frequency:** [e.g., Once daily, every 8 hours, etc.]
- **Duration of Treatment:** [Start Date and End Date]

Access Site & Equipment:

[Specify if Peripheral IV, PICC line, or Port-a-Cath is required].

Special Instructions/Precautions:

[List any allergies, vital sign monitoring requirements, or specific laboratory follow-ups].

Please ensure that all administration protocols are followed in accordance with standard medical practices and that any adverse reactions are documented and reported immediately to my office at [Provider Phone Number].

Thank you for your attention to this patient's care.

Sincerely,

[Physician Signature]
Practitioner Name: [Printed Name]
NPI Number: [NPI Number]
Clinic/Hospital Name: [Organization Name]