Covenant Home Infusion

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7509 Marsha Sharp Fwy Suite 101
Lubbock, TX 79407
806-725-6327 Fax: 806-725-4942

PATIENT INFORMATION **Please include ALL clinical/office notes, lab results, H&P related to therapy, and list of current medications.**	
Patient Name:	Patient Date of Birth:
Patient Phone:	Patient Allergies:
*Home Health:	

***Please note that CHI does not have a nurse on staff to teach TPN administration. If there is no home health, please be sure that the patient is taught at the doctor's office or the hospital prior to discharge. ***

INSURANCE INFORMATION
Please attach FRONT and BACK of all insurance cards

THERAPY OERDER	
Fluid: ☐ Normal Saline ☐ D5 1/2 NS ☐ 1/2 Normal Saline ☐ D5LR ☐ D5NS ☐ Lactated Ringers	
☐ Other: _____	

VOLUME:	FREQUENCY:	RATE OF ADMINSTRATION	
☐ 1 Liter	☐ One time dose	☐ Bolus as tolerated	
☐ 2 Liter	☐ _____ times per week	☐ Over 1 hour	
☐ 500ml	☐ Other: _____	☐ Over 2 hours	
☐ Other:		☐ Over ____ hours	

Additional IV additive medications for infusion:	
☐ **MVI** ☐ **Mag Sulfate IV**: ☐ 1 gm ☐ 2gm ☐ Other: _____	
KCL IV: ☐ 20 meq IV ☐ 40 meq (infuse each 10meq over 1 hour)	

LABS
☐CMP ☐Phosphorous ☐Magnesium ☐Other
☐Frequency/Day to be drawn : ☐ One Time ☐ Weekly ☐ Other: _____

PHYSICIAN INFORMATION		
Physician Name:	NPI:	DEA:
Address:	City:	State, Zip:
Phone:	Fax:	
Physician Signature:	Date:	
Supervising Physician (If NP/PA):		

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