INTRAVENOUS ORDER FORM
Hydration/Medication Infusion for Pregnancy

Infusions are performed at Dermaluxe Injectatbles – 138 Shannon Avenue Geelong West, Vic 3218
Or in the home

PATIENT

NAME: ..... **DOB:** ..... **PHONE:** .....

CLINICAL INFORMATION

ALLERGIES: .....

Medical History: ☐ Pregnant (Gestation in weeks .....) ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

INTRAVENOUS FLUID ORDER

TYPE:	VOLUME:
☐ Normal Saline 0.9%	☐ 500mL
☐ Hartmanns	☐ 1L
	☐ 2L

RATE/DURATION: .....

INTRAVENOUS MEDICATION ORDER

ANTIEMETICS

☐ Maxalon® 10mg

☐ Stemetil® 12.5mg

☐ Ondansetron ☐ 4mg ☐ 8mg

For Hyperemesis Management – Frequency of above order (circle) - Weekly Fortnightly Monthly until (Date) ..... (New Referral required every 8 weeks)

CONSENT ***(Patient MUST sign this consent in the presence of the referring doctor)***

My medical practitioner and I have discussed my present condition(s) and the various ways in which it may be treated, including the above proposed procedure and/or treatment. The doctor has informed me, and I understand:

- The procedure/treatment proposed
- The procedure/treatment carries some risks, and complications may occur, and
- Additional treatments may be needed to achieve the desired results

I understand that I may withdraw my consent. **I request and consent** to the procedure/treatment described above for me.

PATIENT'S SIGNATURE: ..... **DATE:** .....

REFERRING DOCTOR (Drs Signature essential for valid order)

NAME: ..... **PROVIDER No.** .....

ADDRESS: .....

DOCTOR'S SIGNATURE: ..... **DATE:** .....

Please complete and return this form to:
admin@themidwiferycentre.com.au
Patient will be contacted directly to book once referral is received
Patient MUST fill script prior to appointment and bring all MEDICATION to the clinic for infusion.
IV Fluid (Saline and Hartmanns) supplied.