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MAGNESIUM ORDER FORM

\$125 Administration Fee / In-House Pharmacist

Patient information

Name: _____ DOB: _____ Weight: _____ PHN: _____

Address: _____ Allergies: _____

Phone Number: _____ Emergency Contact: _____

Email(required): _____

Prescriber Information

Name: _____ Office/Clinic: _____

Phone number: _____ Fax number: _____

Clinical information:

Diagnosis: _____ Patient pregnant? ___YES, ___NO

Has patient received IV magnesium previously? ___YES, ___NO Previous Reaction? ___YES, ___NO

Details: _____

Prescription

Magnesium Sulfate to be administered by IV Infusion as per product monograph

Dose: ☐ 2gm in 250cc Normal Saline ☐ 4gm in 250cc Normal Saline

Total number of doses: _____

Intervals: ___Weekly___Monthly___2 months___3 months___

Note: Prescribers are responsible for ordering and monitoring patient blood work as well as notifying infusion clinic as soon as patient no longer requires above treatment.

If patient has a history of, or develops a reaction (before, during, or after infusion), Give:

___Methylprednisolone 125mg IV

___Diphenhydramine 25-50mg PO/IV

___Acetaminophen 650mg PO

___Hydrocortisone 100mg IV

___Dimenhydrinate (Gravol®) 25-50mg PO/IV

___Other _____

** Current infusion reaction includes the use of above medications according to nurse/paramedic assessment

Prescriber Signature: _____ Prescriber Name (Printed): _____ Date: _____

Please fax the completed form to 587-805-2539

By faxing, the prescriber confirms patient consent for Solis Medical Clinic and affiliated pharmacy to contact patient.