immersiv HEALTH

MAGNESIUM ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ E83.42 Hypomagnesium

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & failed Therapies

☐ Most recent History & Physical

☐ Magnesium level within 30 days

MEDICATION ORDER

MAGNESIUM SULFATE _____ gm IV in 250 ml – 500 ml NS per protocol

☐ One time dose

☐ Repeat every _____ weeks for _____ total doses

☐ **OTHER:** _____

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN