IVHEALTH CENTER

Fax:_____Phone:_____

Name _____

DOB_____
ID#_____

Weight _____ **Date** _____

Glycyrrhizin Order

Diagnosis: (ICD-10 code) _____ - Description_____

For Provider

(Circle all that apply)

- Request macronutrients lab test
- Request CBC
- Request BMP
- Request G6pd deficiency (Required for any infusion involving vitamin C)

Infusion Medication

- Use 0.9% ns or 0.45% ns 100-1000ml
- 40-60mg IV on infusion 1, 2, and 3. (twice weekly) as a test dose infused 1-3 hours depending on patient toleration

Increase dosage increments of 40 until a max of 200mg if tolerated. Use blood pressure and biweekly cmp to monitor tolerance

_____ Initial if Provider approves the mixture

Pre-Meds

If no pre medications needed please leave blank

- _____
- _____
- _____
- _____
- _____

Additional Orders

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____