**Please include H&P/ current medications list/ allergies, and ensure that med authorizations have been obtained**

*For Blood Transfusions, please ensure that signed consent has been obtained.*

** Prior authorization obtained (if needed) ___ Yes

** Medication: ________________________________

** Dose: ___mg  ___mcg  ____ mL  ____ mL/kg  ____ units/mL  Other: ____________________________

** Route: ________________________________

** Length of Treatment: ___ minute(s) ___ hour(s)

** Frequency:

- ___ once
- Every: ____ day  ____ week  ____ month  ____ year
- Total duration of treatments: ____ day(s)  ____ week(s)  ____ month(s)
- Other: ________________________________

** Additional Info: