IV Nutrition Order Form

WEST END PHARMACY
101 Tara Commons Drive, Suite 100
Loganville, GA 30053
Phone: 470-220-7232
Fax: 470-220-7233

OFFICE NAME:
OFFICE ADRESS:
OFFICE PHONE:
OFFICE FAX:

Patient Information

Name:	**DOB:**
STREET ADDRESS:	
CITY:	**STATE/ZIP:**
PHONE:	
ALLERGIES:	**SEX:**

☐ **Myers Cocktail: 2x5 ml vials for total 10ml**
Thiamine (B1) 10mg/Riboflavin-5-Phosphate (B2) 0.2mg/Niacinamide(B3)/Dexpanthenol (B5)25mg/Pyridoxine (B6) 10mg/Hydroxocobalamin 0.1mg/Magnesium Chloride 100mg per 10ml
Sig: Infuse Myers Coctail _____ time(s) weekly for _____ weeks. To be administered by healthcare provider

Quantity : ☐ 10ml ☐ 20ml ☐ 30ml ☐ 40ml

☐ **Ascorbi Acid: 2x 5ml vials for total 10 ml {500mg/ml}**
Sig: Add Ascorbic Acid and Myers Cocktail to IV bag and infuse within 1 hour of mixing. To be administered by healthcare provider

Quantity: ☐ 10ml ☐ 20ml ☐ 30ml ☐ 40ml

REFILL: 0 1 2 3 4 5 ☐ Ship to Office ☐ Office Pickup

Prescriber Name: _____ **NPI:** _____
Prescriber Signature: _____ **Date:**_____

Fax Completed Form to West End Pharmacy Loganville
Fax:470-220-7233