Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

Fluphenazine orders

INFUSE ONE

Patient Name ______________________________ DOB ____________

Phone Number ___________________________ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ ______________ Schizophrenia

☐ ________________ Other

PRE-MEDICATIONS (optional)

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _______________________ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ______________________ (other)

Fluphenazine ORDERS

DOSAGE & FREQUENCY

☐ 12.5mg once every 2 weeks
☐ 25mg once every 2 weeks
☐ ____________________ Other

Patient Weight

________ **lbs**
________ **kg**

ROUTE:
☐ IM
☐ SQ

NOTES:

ORDERING PROVIDER

Signature __________________________________ Phone__________________Fax__________________

Provider ____ Date __________________