vitamindrip® PATIENT VISIT FORM

Your life, just **better.**™

File Number: Start Time: End Time:

Patient Information

Patient Name:

Patient Address:

Date of Birth:

Email: Phone:

Vitamindrip® Intravenous Treatment Details

Vitamindrip® Formula:

Estimated time of infusion:

Drip rate:

Timing of additions/pushes:

Insertion & Site:

Number of attempts:

Expiry dates checked ☐

Patient instructed to limit movement ☐

Assessment of insertion site:

Patient aftercare recommendations:

PRE Vitamindrip® Intravenous Treatment Vitals

Blood Pressure:

Pulse:

%O2:

Temperature:

Respiratory Rate

DURING (>30 mins.) Vitamindrip® Intravenous Treatment Vitals

Blood Pressure:

Pulse:

%O2:

Temperature:

Respiratory Rate

POST Vitamindrip® Intravenous Treatment Vitals

Blood Pressure:

Pulse:

%O2:

Temperature:

Respiratory Rate

Notes:

Medical Professionals Information

Print Physician Name: Signature: Date:

Print Staff Name: Signature: Date:

FDA REGISTERED 503B Outsourcing Facility