FJÖR
INTEGRATED WELLNESS

INFUSION TREATMENT AUTHORISATION

This authorisation is for the administration of prescribed IV therapy by Fjör, including vitamin, nutrient and other prescriber-directed infusions.

PATIENT DETAILS

Patient name: _____ Date of birth: _____ Phone: _____

Current weight (kg): _____

CLINICAL INFORMATION

Indication for IV therapy: _____

Known allergies: _____

Pregnant: ☐ Yes ☐ No ☐ N/A If yes, current gestation (weeks): _____

Relevant clinical information / precautions: _____

** PLEASE ISSUE A VALID PRESCRIPTION TO THE PATIENT FOR ALL REQUESTED MEDICATION(S) **

INFUSION TREATMENT ORDER

I authorise Fjör to administer the following IV treatment to the above-named patient:

PRESCRIBED TREATMENT

Medication (name and form): _____

Dose: _____ Diluent / volume (if specified): _____

Administration rate / total duration: _____

Additional administration instructions: _____

FJÖR DOES NOT OFFER INFUSIONS IN EXCESS OF THREE (3) HOURS.

TREATMENT SCHEDULE

☐ Single treatment only ☐ Repeat treatment every _____ week(s), for _____ treatment(s)

☐ Other: _____

MEDICATION SUPPLY

☐ Patient has been issued a prescription and will bring the dispensed medication to Fjör

☐ Other arrangement: _____

PRESCRIBER AUTHORISATION

I confirm that I have assessed this patient and authorise administration of the IV treatment specified above.

Prescriber name: _____ Provider / AHPRA number: _____

Practice / Clinic: _____ Practice phone: _____

Email: _____

Prescriber signature: _____ Date: _____

FOR FJÖR USE

Authorisation reviewed by RN: _____ Date: _____

☐ Treatment instructions complete ☐ Prescription / dispensed medication confirmed ☐ Pre-infusion assessment completed

☐ Fjör patient consent completed ☐ Suitable to proceed

Notes: _____

Fjör Integrated Wellness · Suite 12, 200 Malop St Geelong VIC 3220 · 0493 016 456 · admin@fjor.com.au