

**IV Nutritional Therapy Setup Consultation**

**Intake Information:**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Providers in the Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Individuals to be Present at the Consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of anticipated IV’s per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Preferred Dates for Consultation Set-Up***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you attended the **IIVNTP** “*Fundamentals and Clinical Applications*

 *of IV Nutrient Therapy*” Course? 🞎 Yes | 🞎 No

Date of Attendance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you enrolled in a future **IIVNTP** course? 🞎 Yes | 🞎 No

Are you currently doing infusions? 🞎 Yes | 🞎 No

If yes, what infusions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Why are you seeking a consultation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Complete the *NEEDS ASSESSMENT***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| NEEDS ASSESSMENT:How Comfortable Are You?We are committed to providing you with the best experience possible and would like to assess your comfort level on key elements involving an Infusion Clinic. Please rate the following. Thank you.**Please rate your comfort level with mixing IV solutions.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of USP standards involving admixing.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of USP standards involving storage of vials and IV solutions.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of proper disposal of sharps, vials, and ingredients.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of required emergency equipment, supplies, and medications.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of osmolarity and calculating the osmolarity of IV solutions.** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of the recommended safety labs needed prior to infusing patients (i.e. G6PD).**🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

**Please rate your knowledge of aseptic and sterile technique?** 🞎 1 🞎 2 🞎 3 🞎 4 🞎 5

|  |  |
| --- | --- |
| No Experience | Expert |

 |  | **Do you have ……..**Consent for IV? 🞎 Yes | 🞎 NoEducational Tools for Patients? 🞎 Yes | 🞎 NoPost Infusion Instructions? 🞎 Yes | 🞎 NoSOP’s Written for IV Protocols? 🞎 Yes | 🞎 NoEMR? (or a way to document?) 🞎 Yes | 🞎 NoVendor Accounts Set-Up? 🞎 Yes | 🞎 No Compounding Pharmacy? 🞎 Yes | 🞎 No Lab Company? 🞎 Yes | 🞎 No Medical Supply Company? 🞎 Yes | 🞎 No Medical Waste/Sharps Pick-up? 🞎 Yes | 🞎 No Linen? 🞎 Yes | 🞎 No Cleaning Service? 🞎 Yes | 🞎 NoCentrifuge? 🞎 Yes | 🞎 NoProperly Trained Staff? 🞎 Yes | 🞎 NoRefrigerators (medications, labs)? 🞎 Yes | 🞎 NoHood? 🞎 Yes | 🞎 No**Did you ……**Add IV’s to your Medical Malpractice Insurance? 🞎 Yes | 🞎 No ? 🞎 Yes | 🞎 No ? 🞎 Yes | 🞎 No

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| **Please share any additional comments or needs pertaining to having an Infusion Clinic.**  |
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| **NAME:** |
| **PHONE:** |
| **DATE ASSESSMENT COMPLETED:** |

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