



**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? _____

Why are you seeking a consultation? _____

Please Complete the NEEDS ASSESSMENT

NEEDS ASSESSMENT:

Do you have

Consent for IV?

Yes | No

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

- Educational Tools for Patients? Yes | No
- Post Infusion Instructions? Yes | No
- SOP's Written for IV Protocols? Yes | No
- EMR? (or a way to document?) Yes | No
- Vendor 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 | No
- Centrifuge? Yes | No
- Properly Trained Staff? Yes | No
- Refrigerators (medications, labs)? Yes | No
- Hood? Yes | No

Did you

- Add IV's to your Medical Malpractice Insurance? Yes | No
- ? Yes | No
- ? Yes | No

Please share any additional comments or needs pertaining to having an Infusion Clinic.

NAME:

PHONE:

DATE ASSESSMENT COMPLETED:
