

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

ICD-10 Diagnosis: _____

Rx:

Levothyroxine _____ mcg IV Push diluted in 0.9% NaCl over a max rate of 100 mcg/minute.

Once Weekly Other: _____

Labs: _____

Lab Frequency: _____

Order good for: Once 3 months 6 months 1 year Other: _____

Other orders/comments: _____

Port/PICC care per protocol will be performed if applicable including Heparin flush (500 units/5 mL) and Cathflo (2 mg) as needed for patients with a port.

Prescriber printed name: _____

Prescriber full address: _____

Office phone number: _____ **Office fax number:** _____

Prescriber signature

Date

Time

Questions? Call (419) 591-3858. Please fax completed form to (419) 592-4004.



LEVOTHYROXINE ORDER FORM

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TRIAL

This document is currently being trialed.