NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax: 207-692-2473

Magnesium Repletion Order

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

☐ 1gm Mg /100ml NS: ☐ 2gm Mg/100ml NS: ☐ Other _____ Frequency:_____

* Each gram of magnesium will be administered at a rate of no greater than 1 hour

***In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____