

Vitamin C Protocol

Treatment Protocol for Vitamin C Infusions

Effective Date: _____ dd / mm / yyyy

Reviewed Date: _____ dd / mm / yyyy

Medical Director / Prescribing Provider:

Clinic/Business/Provider Name: _____

Clinic/Business/Provider Responsible Party Signature
Approved Providers

PURPOSE: To establish compliant and legal guidelines for the administration of vitamin c infusions.

PROCEDURE FOR VITAMIN C INFUSION:

Client completes an intake form. An initial consultation is performed; see Pre-treatment evaluation section below.

REQUIREMENTS: In compliance with state regulations, the pretreatment evaluation is performed by a RN, PA, physician, or an advanced practice registered nurse (APRN). In compliance with state regulations, vitamin c infusions are performed by a physician, APRN or registered nurse (RN).

PRE-TREATMENT EVALUATION - Practitioner will document a minimum of the following:

DOCUMENTATION REQUIREMENTS

Documentation Requirements

- | | |
|---|--|
| ☐ Vital signs | ☐ Medical history and assessment |
| ☐ Patient consent form | ☐ Medication and dosage |
| ☐ Size catheter and location | ☐ Inserted using aseptic technique |
| ☐ Time of Injection | ☐ No adverse reactions noted |
| ☐ Cotton ball and Coban dressing applied | ☐ Reassessment after 15 minutes or more |
| ☐ Sign and date | |

CONTRAINDICATIONS - The most common contraindications to vitamin C infusions are:

CONTRAINDICATIONS

Contraindications

- ☐ G6PD Deficiency
- ☐ Kidney Disease
- ☐ Hemochromatosis
- ☐ Pregnancy
- ☐ Breastfeeding

Other Contraindications - Vitals signs outside of predetermined ranges:

VITAL SIGN CONTRAINDICATIONS

Vital Sign Contraindications

- ☐ SBP >150, DBP >100
- ☐ HR>100 or
- ☐ RR>24
- ☐ Pulse Ox

ADVERSE REACTIONS - The most common adverse reactions to vitamin C infusions are:

ADVERSE REACTIONS

Adverse Reactions

- ☐ Nausea
- ☐ Diarrhea
- ☐ Abdominal Cramps
- ☐ Kidney stones

DOSING - Vitamin C Protocol:

Medication: _____

Dose Selection

☐ 2,500mg ☐ 5,000mg ☐ 10,000mg OSM = 525 in 500ml NS

Route: _____ Rate: _____

Physician Name: _____ License Number: _____

Physician Signature

Date: _____ dd / mm / yyyy