Good Faith Exam / Provider Clearance for IV Therapy

Hydromedics LLC | Franklin | Spring Hill | Murfreesboro | Columbia, Tennessee

Examining provider: complete sections 1-6, sign, and return to orders@hydromedicsiv.com.

Form GFE-1 Rev. 11/2026

1 PATIENT

Patient full name | Date of birth | Phone

2 EXAMINING PROVIDER Only exams by Tennessee-licensed providers are accepted.

Provider name | NPI | TN license # (Tennessee license required)

Credentials

☐ MD ☐ DO ☐ NP ☐ PA Other:

If NP or PA: collaborating physician (name, license #)

Practice name and location | Phone | Fax

3 EXAM (an exam is required; a questionnaire alone does not qualify)

Exam date | Exam type (choose one) | Telehealth platform used

☐ In person ☐ Telehealth, live audio-video *(audio-only, text or fax not accepted)*

If telehealth: ☐ Patient identity verified and patient located in Tennessee ☐ Under 18: facilitator present (name/role):

Allergies and reactions ☐ No known allergies | Current medications and supplements (or attach list)

Assessment / indication for IV therapy | Vitals and findings (BP, HR, heart/lungs, edema, hydration, veins)

4 CONDITIONS THAT AFFECT IV THERAPY (check all that apply)

☐ Congestive heart failure	☐ Kidney disease / dialysis	☐ Liver disease	☐ Uncontrolled hypertension
☐ Diabetes	☐ Pregnant or breastfeeding	☐ G6PD deficiency	☐ Hemochromatosis
☐ Kidney stones	☐ Bleeding disorder / anticoagulant	☐ Seizure disorder	☐ Cancer / active treatment
☐ **None of the above**	☐ Other / details:		

5 CLEARANCE DECISION (choose one)

☐ **Approved: I consent to my patient receiving IV therapy under HydroMedics protocols** ☐ **Not approved (reason below)**

☐ **Approved with the orders / restrictions below** **Clearance valid for 12 months from the exam date.**

Orders, restrictions, or reason not approved (formula, dose, frequency; ingredients to avoid)

6 PROVIDER ATTESTATION

I hold an active Tennessee license and acted within my scope (NP or PA: under my collaborating physician's protocols). On the exam date I established a provider-patient relationship, personally took a history and examined this patient, reviewed medications and allergies, made the assessment above, and discussed the plan, risks and benefits with the patient. For telehealth, I gave my name, location, degree and specialty. If I approve per HydroMedics protocols, I consent to treatment under them. I or my coverage am available for follow-up, and I will tell HydroMedics of any change that affects this clearance.

Provider signature | Printed name and credentials | Date

7 PATIENT AUTHORIZATION TO RELEASE INFORMATION (optional)

Optional: complete only if the provider's office requires written patient authorization to release records.

I authorize the provider and practice in Section 2 to release this form and records of this exam to Hydromedics LLC (HydroMedics) to evaluate and provide my IV therapy. This expires 12 months after I sign it. I may revoke it at any time in writing to that practice, except for information already released. My care with my provider does not depend on whether I sign. Released information may be shared again by the recipient and may no longer be protected by federal privacy law. I may have a copy of this form.

Patient (or legal representative) signature | Printed name (and relationship if representative) | Date

FOR HYDROMEDICS USE ONLY Date received | Received by | Reviewed by | Clearance expires | ☐ Entered in chart

RETURN TO HYDROMEDICS Email: orders@hydromedicsiv.com Phone: (615) 567-3050 hydromedicsiv.com

CONFIDENTIAL: Contains protected health information (PHI). If received in error, call (615) 567-3050 and destroy all copies.