Antibiotic Referral Form

Fax Completed Form To: **Phone:**

amerita specialty infusion services

mosaic infusion solutions an amerita company

PATIENT INFORMATION

Please include ALL clinical/office notes, lab results, H&P related to therapy and list of current medications/allergies.

Patient Name:	Date of Birth:	Phone:
Patient Weight:	Patient Allergies:	

INSURANCE INFORMATION *Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)*

Diagnosis:	ICD -10

PRESCRIPTION INFORMATION *All necessary supplies will be provided as needed*

Start Date of Therapy:

Medication	**Dose/Route/Directions**	**Duration**	**Quantity**
☐ Ceftriaxone	_____ gm IV every ___ hours	for ___ days	# QS
☐ Daptomycin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Dalbavancin	_____ mg IV every ___ hours	for ___ days	# QS
☐ Ertapenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Meropenem	_____ gm IV every ___ hours	for ___ days	# QS
☐ Nafcillin	_____ gm IV every ___ hours	for ___ days	# QS
☐ Check if Nafcillin is a continuous infusion			
☐ Oritavancin	_____ mg IV every ___ hours	for ___ days	# QS
☐ Piperacillin/Tazobactam	_____ gm IV every ___ hours	for ___ days	# QS
☐ Telavancin	_____ mg/kg IV every ___ hours	for ___ days	# QS
☐ Vancomycin	_____ mg IV every ___ hours	for ___ days	# QS
☐ Check if pharmacy is to clinically manage Vancomycin dosing			

Other IV antibiotic medication:_____

IV Access type: ☐ Peripheral ☐ PICC line ☐ Port ☐ CVAD (Central Venous Access Device) ☐ Admit to Home Health Agency _____

Anaphylaxis Orders: (Nursing to call MD if patient has anaphylactic reaction)

☐ Epinephrine ☐ 1:1000 0.3mL IM as needed for anaphylaxis, and Diphenhydramine ☐ 25-50 mg IM as needed for anaphylaxis

☐ Sodium Chloride 0.9% ☐ mL IV to provide fluid as needed

☐ Other: _____

IV access flushing and line care orders:

☐ Heparin ☐10 units/ml ☐100 units/ml Flush line with 3-5 ml after last saline flush and into unused IV line if needed

☐ Sodium chloride 0.9% Flush line with 5-10 ml before and after each dose of medication infused and into unused IV line if needed

☐ Other: _____

☐ IV site dressing change every ___ days

LAB TESTS:

☐ CBC with DIFF ☐ CMP ☐ BMP ☐ ESR ☐ Other labs _____ ☐ No Labs

Physician Information

Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:		Date:	

By signing this form and utilizing our services, you are authorizing Amerita and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.
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