Antibiotic Referral Form

Fax Completed Form To: **Phone:**

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 Flush line with 3-5 ml after last saline flush and into unused IV line if needed

__100 units/ml

__ 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

Labs to be drawn on ____________ then ____________ thereafter

Physician Information

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

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