

# 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
<input type="checkbox"/> Ceftriaxone	_____ gm IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Daptomycin	_____ mg/kg IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Dalbavancin	_____ mg IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Ertapenem	_____ gm IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Meropenem	_____ gm IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Nafcillin	_____ gm IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Check if Nafcillin is a continuous infusion			
<input type="checkbox"/> Oritavancin	_____ mg IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Piperacillin/Tazobactam	_____ gm IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Telavancin	_____ mg/kg IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> Vancomycin	_____ mg IV every ___ hours	for ___ days	# QS
<input type="checkbox"/> 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:

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.  
**Important Notice:** This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.