

Antibiotic Order Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

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 <i>Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)</i>	
Diagnosis:	ICD -10

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

Start Date of Therapy:

Medication	Dose/Route/Directions	Duration	Quantity
☐ Ampicillin	_____ gm IV every ____ hours	for ____ days	# QS
☐ Ampicillin-sulbactam	_____ gm IV every ____ hours	for ____ days	# QS
☐ Cefazolin	_____ gm IV every ____ hours	for ____ days	# QS
☐ Cefepime	_____ gm IV every ____ hours	for ____ days	# QS
☐ Ceftazidime	_____ gm IV every ____ hours	for ____ days	# QS
☐ Ceftriaxone	_____ gm IV every ____ hours	for ____ days	# QS
☐ Daptomycin	_____ mg/kg IV every ____ hours	for ____ days	# QS
☐ Ertapenem	_____ gm IV every ____ hours	for ____ days	# QS
☐ Gentamicin	_____ mg/kg IV every ____ hours	for ____ days	# QS
☐ Imipenem cilastatin	_____ gm IV every ____ hours	for ____ days	# QS
☐ Meropenem	_____ gm IV every ____ hours	for ____ days	# QS
☐ Nafcillin	_____ gm IV every ____ hours	for ____ days	# QS
☐ Penicillin G potassium	_____ IV units / Day	for ____ days	# QS
☐ Piperacillin-tazobactam	_____ gm IV every ____ hours	for ____ days	# QS
☐ Tobramycin	_____ mg/kg IV every ____ hours	for ____ days	# QS
☐ Vancomycin	_____ gm IV every ____ hours	for ____ days	# QS

Other IV antibiotic medication: _____

Nursing Orders: Nurse to provide assessment, lab draws, medication administration and vascular access device insertion and/or management per physician order

Supply Orders: All supplies for vascular access line care, drug administration kits, pump and IV pole will be provided as necessary

Flush Orders: ☒ 0.9%NaCl 10ml flush pre and post infusion and as needed

Heparin ☐ 10units/ml OR ☐ 100units/ml 5ml flush if indicated to maintain line ☐ Other _____

Lab Orders: ☐ CBC w diff, CMP, CRP ☐ Trough ☐ CPK ☐ ESR ☐ Other _____ Frequency _____

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

Diphenhydramine 50mg IVP x1, Epinephrine 0.3mg IM x1, may be repeated after 15 minutes as needed for severe reactions; 0.9% NaCl IV 500mL

Solu-Medrol ☐ 125mg IV as needed Solu-Cortef ☐ 100mg IV as needed ☐ Other _____

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

☐ 2 mg Cathflo as needed - allow to dwell in catheter for up to 2 hours; second dose if remains occluded

Physician Information

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