Antibiotic Referral Form

Fax Completed Form To: 512-524-1801 Phone: **512-454-9923**
Email To: infusionaustin@nucara.com

NuCara INFUSION SERVICES

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

Name:		Date of Birth:	**Phone:**
Weight (kg):	Height	Allergies:	NKDA: ☐
DX:		ICD -10:	

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

PRESCRIPTION INFORMATION *All necessary supplies to be provided by pharmacy*

Start Date of Therapy: **End Date:**

Medication	**Dose/Route/Interval**	**Quantity**
☐ Cefazolin	_____ gm IV Q ___ hours	*Sufficient for therapy duration,*
☐ Cefepime	_____ gm IV Q ___ hours	*to be calculated by pharmacy.*
☐ Ceftriaxone	_____ gm IV Q ___ hours	
☐ Daptomycin	_____ mg IV Q ___ hours	
☐ Ertapenem	_____ gm IV Q ___ hours	
☐ Meropenem	_____ gm IV Q ___ hours	
☐ Nafcillin	_____ gm IV Q ___ hours	
☐ Nafcillin as continuous infusion	_____ gm over 24 hours	
☐ Piperacillin/Tazobactam	_____ gm IV Q ___ hours	
☐ Unasyn	_____ gm IV Q ___ hours	
☐ Vancomycin	_____ mg IV Q ___ hours	

☐ RPh to clinically manage Vancomycin dosing

Other IV antibiotic:_____

IV Access: ☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ Central Venous Access Device

IV Maintenance and Care:
☐Sodium chloride 0.9% Flush line with 10 ml before and after each dose and unused lumen daily and PRN
☐ No Heparin Heparin: ☐ 10 units/ml ☐ 100 units/ml Flush line with 3-5 ml after last saline flush and unused lumen daily and PRN
☐ Alteplase (Cathflo Activase) 2mg IV per lumen PRN to restore catheter patency. May repeat dose after one hour PRN.

Weekly labs: ☐ No Labs Ordered
☐ CBC with DIFF ☐ CMP ☐ BMP ☐ ESR ☐ CRP ☐ Vancomycin Trough ☐ Other Labs: _____

Home Health Orders:
☐ Admit to Home Health **Agency Name:**_____
☐ Evaluate and treat, with weekly and PRN IV dressing changes, provide education to pt / caregiver, and draw ordered labs
☐Remove catheter at end of therapy ***Please use NuCara CPL requistion form OR fax results to: 512-524-1802***

First Dose Orders: (Nursing to call MD for anaphylactic reaction)
☐ Epinephrine 1:1000 0.3ml IM ☐ Diphenhydramine: 25-50 mg IV slow push over 3 minutes ☐ Other: _____

PHYSICIAN INFORMATION

Prescriber:		NPI #:	
Phone:	Fax:		
Address:	City:	State:	Zip:
Following Physician:	Phone	Fax:	
Prescriber Signature:		Date:	

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