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: 512-524-1801***

For Adverse Reaction Clinic: Per protocol / notify prescriber. Home PRN: Administer med / call 911. Notify prescriber.
Epinephrine 1:1000 (1mg/ml) 0.3ml IM Diphenhydramine: 25-50 mg slow IVP over 3 minutes.

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.
Important Notice: This transmission may contain confidential health information that is legally protected. 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.