

# Antibiotic Referral Form

Fax Completed Form To: 512-524-1801 Phone: 512-454-9923

Email To: [infusionaustin@nucara.com](mailto:infusionaustin@nucara.com)



## 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: <input type="checkbox"/>
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
<input type="checkbox"/> Cefazolin	_____ gm IV Q ____ hours	Sufficient for therapy duration,
<input type="checkbox"/> Cefepime	_____ gm IV Q ____ hours	to be calculated by pharmacy.
<input type="checkbox"/> Ceftriaxone	_____ gm IV Q ____ hours	
<input type="checkbox"/> Daptomycin	_____ mg IV Q ____ hours	
<input type="checkbox"/> Ertapenem	_____ gm IV Q ____ hours	
<input type="checkbox"/> Meropenem	_____ gm IV Q ____ hours	
<input type="checkbox"/> Nafcillin	_____ gm IV Q ____ hours	
<input type="checkbox"/> Nafcillin as continuous infusion	_____ gm over 24 hours	
<input type="checkbox"/> Piperacillin/Tazobactam	_____ gm IV Q ____ hours	
<input type="checkbox"/> Unasyn	_____ gm IV Q ____ hours	
<input type="checkbox"/> Vancomycin	_____ mg IV Q ____ hours	
<input type="checkbox"/> RPH to clinically manage Vancomycin dosing		
Other IV antibiotic: _____		
IV Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> PICC <input type="checkbox"/> Midline <input type="checkbox"/> Port <input type="checkbox"/> 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 requisition 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.

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