

Antibiotic Referral Form

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



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
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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

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

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 follow patient for dressing change and lab draw _____

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:

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

Physician Information

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

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