Medical Center
PHARMACY
Service Delivery Trust Since 1924

Anti-Infective

Phone # 1-844-546-7577 • 619-263-1998
Fax # 1-844-240-2518 • 619-243-3245

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email : _____
Last 4# of SS: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Name: _____
State License #: _____ NPI: _____
DEA #: _____ Tax ID _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION **If available, please fax copy of prescription insurance cards with this form (front and back).**

DIAGNOSIS AND CLINICAL INFORMATION

Primary Diagnosis: _____ Height: _____

Secondary Diagnosis: _____ Weight: _____

Allergies: _____

Diabetic: ☐ Yes ☐ No Insulin Dependent: ☐ Yes ☐ No

PRESCRIPTION

	Anti-Infective Therapy 1		Anti-Infective Therapy 2	
Therapy Ordered	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane/Tazobactam ☐ Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane/Tazobactam ☐ Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____
Services Ordered	☐ Pharmacy only ☐ Home Health ☐ Nursing/HHA Name:	Is patient Homebound? ☐ Yes ☐ No		
Flushing	☐ NS 5 ml SASH and prn Heparin ☐ 20 units ☐ Heparin 100 units SASH and prn	Access: None ☐ or Type: _____ Date inserted: _____		

Following Physician: _____ Phone: _____

Anticipated time of Discharge Home: Time _____ Date _____

Hospital Name _____ Location _____

Referral Contact Name _____ Phone _____ Fax _____

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: **Date:**

Dispense as written	**Date**	**Substitution Premissable**	**Date**

# of Prescriptions: _____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102