IV Antibiotics – Physician Orders

Please fax completed referral form to (804) 554-5848

PATIENT DEMOGRAPHICS

Patient's Name: _____ DOB: _____ Phone #: _____
Address: _____ City/State/Zip: _____
Allergies: _____ ☐ NKDA Weight: _____ (lbs)/ _____ (kg) Height: _____

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS *(ICD 10 Code Required)*

☐ _____, ICD 10_____ ☐ _____, ICD 10_____

INFUSION ORDERS

Antibiotics will be dispensed in an elastomeric device (ED) for administration unless specified otherwise or as required by insurance.

☐ Avycaz® 2.5 gm IV over 2 hours via gravity q8hr x _____ ☐ days ☐ weeks
☐ Cefazolin _____ gm IV over 30 minutes q8hr x _____ ☐ days ☐ weeks
☐ Cefepime _____ gm IV over 30 minutes q12hr x _____ ☐ days ☐ weeks
☐ Ceftriaxone _____ gm IV over 30 minutes q24hr x _____ ☐ days ☐ weeks
☐ Dalvance® IV over 30 minutes via SP
  ☐ 1500 mg x 1 dose
  ☐ 1000 mg, followed one week later by 500 mg
  ☐ Other: _____
☐ Daptomycin IV over 30 minutes q24hr x _____ ☐ days ☐ weeks
  ☐ _____ mg/kg ☐ _____ mg
☐ Ertapenem 1 gm IV over 30 minutes q24hr x _____ ☐ days ☐ weeks
☐ Meropenem _____ mg IV over 30 minutes q24hr x _____ ☐ days ☐ weeks
☐ Piperacillin-Tazobactam _____ gm IV over 30 minutes q____hr x _____ ☐ days ☐ weeks
☐ Teflaro® 600 mg IV over 1 hour via gravity q12hr x _____ ☐ days ☐ weeks
☐ Vabomere® 4 gm IV over 3 hours q8hr x _____ ☐ days ☐ weeks
☐ Vancomycin IV over 90 minutes q____hr x _____ ☐ days ☐ weeks
  ☐ _____ mg/kg -or- ☐ _____ mg
  - Vancomycin trough levels before 4th dose, then weekly.
☐ Vibativ® IV over 1 hour q24hr x _____ ☐ days ☐ weeks
  ☐ _____ mg/kg -or- ☐ _____ mg
  - SCr q48-72hr for first 2 weeks of therapy.
☐ Xerava® IV over 1 hour q12hr x _____ ☐ days ☐ weeks
  ☐ _____ mg/kg -or- ☐ _____ mg
☐ Zerbaxa® IV over 1 hour q8hr x _____ ☐ days ☐ weeks
  ☐ 1.5 gm ☐ 3 gm ☐ Other: _____
☐ Other: _____
☐ Other: _____

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES
If yes, Facility Name: _____ Date of last treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Solutions ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q _____ ☐ BMP q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____
☐ Other: _____

ADDITIONAL ORDERS: _____

CLINICAL DOCUMENTATION

Please attach most recent H&P or MD progress note, medication list, and lab/test results to support diagnosis.

Lab Results: Please attach copy for all items checked.
☐ Culture and sensitivity report
☐ For patients currently receiving vancomycin or aminoglycosides – need most recent labs and drug trough level
☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/State/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Emails Where Follow Up Documentation Should Be Sent: _____