

REFERRING OFFICE, FAX COMPLETED ORDER WITH THE FOLLOWING:

- Patient demographic sheet
- FRONT and BACK copies of all insurance cards
- Supporting clinical notes
- Most recent labs



375 E. Millsap Rd., Suite 3
 Fayetteville, AR 72703
 (p) 479-445-6833 (f) 479-445-6032

PATIENT INFORMATION			
Name:	Date of Birth:	Height:	Weight:
Allergies:			
Diagnosis:		ICD-10:	
ANTI-INFECTIVE PRESCRIPTION INFORMATION			
<i>all necessary infusion supplies will be provided as needed for the duration of therapy</i>			
Start Date:		End Date: OR Duration:	
Medication	Dose/Route/Frequency	Quantity	
<input type="checkbox"/> Cefazolin	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Check if Cefazolin is a continuous infusion			
<input type="checkbox"/> Cefepime	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Check if Cefepime is a continuous infusion			
<input type="checkbox"/> Ceftriaxone	<input type="checkbox"/> ___ gram(s) IV every ___ hours <input type="checkbox"/> ___ grams(s) mixed with 1% lidocaine IM every ___ hours	___ doses	
<input type="checkbox"/> Ciprofloxacin	___ mg IV every ___ hours	___ doses	
<input type="checkbox"/> Dalbavancin	<input type="checkbox"/> 1.5 grams IV as a single dose <input type="checkbox"/> 1 gram IV as a single dose follow by 500mg IV 1 week later	___ doses	
<input type="checkbox"/> Daptomycin	___ mg IV every ___ hours	___ doses	
<input type="checkbox"/> Ertapenem	<input type="checkbox"/> ___ gram(s) IV every ___ hours <input type="checkbox"/> ___ grams(s) mixed with 1% lidocaine IM every ___ hours	___ doses	
<input type="checkbox"/> Levofloxacin	___ mg IV every ___ hours	___ doses	
<input type="checkbox"/> Meropenem	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Nafcillin	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Check if Nafcillin is a continuous infusion			
<input type="checkbox"/> Penicillin G	___ million units IV every ___ hours	___ doses	
<input type="checkbox"/> Check if Penicillin G is a continuous infusion			
<input type="checkbox"/> Piperacillin/Tazobactam	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Check if Piperacillin/Tazobactam is a continuous infusion			
<input type="checkbox"/> Vancomycin	___ gram(s) IV every ___ hours	___ doses	
<input type="checkbox"/> Check if pharmacy is to clinically manage Vancomycin dosing. Note: pharmacy will adjust vancomycin based on trough levels with a goal of 15-20 mcg/mL unless ordered otherwise			
<input type="checkbox"/> Other:		___ doses	
IV Access type: <input type="checkbox"/> PICC line <input type="checkbox"/> Midline <input type="checkbox"/> Port <input type="checkbox"/> Peripheral			
IV line will be pulled promptly after completion of IV antibiotics unless ordered otherwise			
<input type="checkbox"/> Anaphylaxis kit: Epinephrine 1mg/mL 1 mL vial and diphenhydramine 50mg/mL 1 mL to be administered per Infuse Rx anaphylaxis protocol			
Line Maintenance:			
<input type="checkbox"/> 10mL 0.9% Sodium Chloride flush before and after each dose of medication and PRN for line maintenance Qty: QS			
<input type="checkbox"/> IV site dressing change every ___ days			
<input type="checkbox"/> Other: _____			
Lab Orders to be drawn every _____ days:			
<input type="checkbox"/> CBC with Diff <input type="checkbox"/> CMP <input type="checkbox"/> BMP <input type="checkbox"/> ESR <input type="checkbox"/> CPK <input type="checkbox"/> Vancomycin trough <input type="checkbox"/> Other: _____			
<input type="checkbox"/> No Labs needed			
Nursing services to be provided by: <input type="checkbox"/> Infuse Rx <input type="checkbox"/> _____ Home Health Agency			
PRESCRIBER INFORMATION			
Referral Coordinator name:		Phone number:	
Provider Name:		Provider NPI:	
Provider Signature:			Date:
To be completed by Infuse Rx only for billing purposes: <input type="checkbox"/> S9500 <input type="checkbox"/> S9501 <input type="checkbox"/> S9502 <input type="checkbox"/> Other: _____			