SPECIALTY
INFUSION CENTER
An Access Infusion Care Company

ANTIBIOTIC ORDERS

PATIENT INFORMATION

Name: ______________________ DOB: __________ Height: ______ Weight: ______

Address: ______________________ Phone: __________ Allergies: ______

City, State, Zip: ______________________ Email: __________

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: __________ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Diagnosis: ______________________ ICD-10 Code: ______________________

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

Drug	Dose	Route/Frequency	Duration	
☐ Cefazolin (Ancef)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Cefepime (Maxipime)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Ceftriaxone (Rocephin)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Daptomycin (Cubicin)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Ertapenem (Invanz)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Meropenem (Merrem)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Nafcillin (Unipen)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Piperacillin/Tazobactam (Zosyn)	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Vancomycin	______	IV Every ______ hours	X ______ days	X ______ weeks
☐ Other: ____________	______	IV Every ______ hours	X ______ days	X ______ weeks

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: ______________________

Lab orders: ______________________ Frequency: ☐ Weekly ☐ Other: __________

Labs to be drawn by: ☐ Home Health Nurse ☐ Prescriber

PRESCRIBER INFORMATION

Prescriber Name: ______________________ NPI Number: __________

Office Phone: ______________________ Office Fax: __________

Prescriber Signature: ______________________ Date: __________

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