SPECIALTY INFUSION CENTER
An Access Infusion Care Company

ANTIBIOTIC ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST

Please ensure the following information is included with your referral:

- ☐ Patient Demographics and Contact Information
- ☐ Patient Insurance Information
- ☐ Completed H&P and Progress Notes Including Medications and Allergies
- ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
- ☐ Completed and Signed Referral

Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.
Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Height: Weight: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last infusion:

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS

☐ Dx Code and description:

REQUIRED DOCUMENTATION

☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

PRESCRIBING INFORMATION

LAB ORDERS-to be drawn by ☐ **Home Health Nurse** ☐ **Prescriber**

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other:

MEDICATION

Medication	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

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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