

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
 ANTIBIOTICS ORDER FORM**

STAT REFERRAL

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ kg Sex: () Male () Female Allergies: () NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

PRIMARY DIAGNOSIS: _____ **SECONDARY DIAGNOSIS:** _____

Does patient have venous access? YES NO If "YES", what type? MEDIPORT PIV PICC LINE MID LINE OTHER: _____

PICC LINE INSTRUCTIONS MUST BE SELECTED (Check the option): D/C PICC AFTER LAST DOSE PERFORM LINE CARE PER HOSPITAL PROTOCOL UNTIL LINE IS REMOVED

- a) ALL MEDIPORTS/IV ACCESSES MAY BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
 b) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL PROTOCOL FOR PATIENT SAFETY

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Vancomycin	500 mg	IV		
	Vancomycin	750 mg	IV		
	Vancomycin	1000 mg	IV		
	Vancomycin	1500 mg	IV		
	Vancomycin	1750 mg	IV		
	Vancomycin	2000 mg	IV		
	Rocephin (Ceftriaxone)	250 mg	() IV () IM		
	Rocephin (Ceftriaxone)	500 mg	() IV () IM		
	Rocephin (Ceftriaxone)	750 mg	() IV () IM		
	Rocephin (Ceftriaxone)	1000 mg	() IV () IM		
	Rocephin (Ceftriaxone)	2000 mg	() IV () IM		
	Invanz (Ertapenem)	500 mg	() IV () IM		

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Invanz (Ertapenem)	1000 mg	() IV () IM		
	Merrem (Meropenem)	500 mg	() IV		
	Merrem (Meropenem)	1000 mg	() IV		
	Gentamicin (Garamycin)		() IV		
	Gentamicin (Garamycin)	7mg/kg	() IV		
	Levaquin (Levofloxacin)	250 mg	IV		
	Levaquin (Levofloxacin)	500 mg	IV		
	Levaquin (Levofloxacin)	500 mg	IV		
	Levaquin (Levofloxacin)	750 mg	IV		
	Dalvance (Dalbavancin)	1500 mg	IV	NA	X 1 Dose
	Dalvance (Dalbavancin)	1000 mg Day 1, 500mg Day 8	IV		
	Orbactiv (Oritavancin)	1200 mg	IV		

Other (not listed): _____

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA
	BMP	PRIOR () POST ()	
	CMP	PRIOR () POST ()	
	BUN/CREATININE	PRIOR () POST ()	
	CRP	PRIOR () POST ()	
	ESR	PRIOR () POST ()	
	ALT	PRIOR ()	
	VANCO TROUGH		
	GENT TROUGH		

SELECT	LAB REQUESTED	WHEN	FREQUENCY
	CK	PRIOR () POST ()	
	UA	PRIOR () POST ()	
	Other:	PRIOR () POST ()	
	Other:	PRIOR () POST ()	
	Other:	PRIOR () POST ()	
	Other:	PRIOR () POST ()	
	Other:		
	Other:		
	Other:		

NOTES: _____

Physician's Signature _____ Time _____ Date _____
 *Signature must be clear and legible

Co-Signature (If Required) _____ Time _____ Date _____
 *Signature must be clear and legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.