ANTIBIOTICS INFUSION ORDER FORM

REQUIRED INFORMATION

☐ Patient demographics & insurance information
☐ This signed order form from the provider
☐ Date and level of last Creatinine: _____ / _____mg/dL
☐ HPI – Note (Insurance Purposes)
☐ Culture/sensitivity(s) if available

Patient Name: _____ DOB: _____

Allergies & Reactions: ☐NKDA _____

If the rest of this form is left blank, we will assume that you would like for the Infectious Disease doctor on call to order the antibiotics for your patient.

DIAGNOSIS

☐ Cellulitis/abscess of: _____
☐ Septic arthritis of: _____
☐ Pneumonia (486)
☐ Diverticulitis (562.11)
☐ Prosthetic infection of: _____
☐ Osteomyelitis of: _____
☐ Chronic Sinusitis (473.9)
☐ Intra-abdominal abscess (567.22)
☐ Diabetic wound of: _____
☐ MRSA/MSSA of: _____
☐ Complicated UTI (599.0)
☐ Other: _____

ROUTE

☐ PICC Line ☐Tunneled PICC ☐ Peripheral IV ☐ Port ☐ Weekly Dressing Change

MEDICATION

☐ Cefazolin (Ancef) 1gm
☐ Metronidazole (Flagyl) 500mg
☐ Gentamicin _____mg
☐ Zosyn ☐3.375g ☐4.5gm
☐ Meropenem (Merrem) _____mg
☐ Ceftriaxone (Rocephin) ☐1gm ☐2gm
☐ Tigecycline (Tigacil) 100mg followed by 50mg Q24hr
☐ Vancomycin ☐500mg ☐1000mg ☐_____mg
☐ Benadryl 12.5mg iv x1 dose PRN for skin rash or itching
☐ Daptomycin (Cubicin) ☐4mg/kg ☐6mg/kg
☐ Ertapenem (Invanz) ☐1gm ☐500mg if GFR <30
☐ Ceftazidime (Fortaz) ☐1gm ☐2gm
☐ Cefepime (Maxipime) ☐1gm ☐2gm
☐ Imipenem (Primaxin) ☐250mg ☐500mg
☐ Tobramycin _____mg
☐ Caspofungin (Cancidas) 70mg followed by 50mg Q24hr
☐ Other: _____
☐ Decadron 2mg iv x1 dose PRN for severe hash, hives or wheezing

*All orders will be administered per Infusion Solutions of Delaware, LLC protocol, unless otherwise specified

FREQUENCY

☐Q48hr ☐Daily ☐Q12hr ☐Q8hr ☐Q6hr _____ x Days _____ x Weeks

Start Date: _____ End Date: _____

WEEKLY LAB ORDERS

☐ CBC ☐CMP ☐CPK ☐ESR ☐ CRP ☐Gentamicin trough ☐Vancomycin trough

Physician Name _____ Phone _____ Fax _____
Signature _____ Date _____

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