SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

ANTIBIOTICS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ 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** ☐ **OTHER:**_____

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

a) ALL MEDIPORTS/IV ACCESSES MAY BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
c) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL POLICY 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)	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:		IV		

OTHER MEDICATION (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.