ANTIBIOTIC INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Height: _____ Diabetic ☐ Yes ☐ No
Allergies: _____
Primary Diagnosis: _____ ICD-10 Code: _____

THERAPY ORDER

- ☐ Acyclovir
- ☐ Amikacin
- ☐ Amphotericin B
- ☐ Ampicillin/Sulbactam (Unasyn)
- ☐ Avycaz
- ☐ Cefazolin
- ☐ Cefepime (Maxipime)
- ☐ Ceftazidime (Fortaz)
- ☐ Ceftriaxone (Rocephin)
- ☐ Cipro
- ☐ Clindamycin
- ☐ Cubicin
- ☐ Dalvance
- ☐ Doribax
- ☐ Fluconazole
- ☐ Gentamicin
- ☐ Imipenem/Cilastatin (Primaxin)
- ☐ Invanz
- ☐ Kimyrsa
- ☐ Levaquin
- ☐ Metronidazole (Flagyl)
- ☐ Merrem
- ☐ Mycamine
- ☐ Nafcillin
- ☐ Orbactiv
- ☐ Oxacillin
- ☐ Piperacillin/Tazobactam (Zosyn)
- ☐ Teflaro
- ☐ Tigecycline
- ☐ Timentin
- ☐ Tobramycin
- ☐ Tygacil
- ☐ Vancomycin
- ☐ Vibativ
- ☐ Xerava

☐ Other: _____ ☐ Do not substitute

Dose: _____ mg _____ grams _____ mg/kg
Frequency: ☐ One Dose ☐ Daily ☐ Every _____ days ☐ Other: _____
Duration: _____ days _____ weeks **Route:** ☐ IV ☐ IM ☐ Other: _____
Flush orders: ☐ NS 1-20mL pre/post infusion PRN ☐ D5W 1-20mL pre/post infusion PRN

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine 25-50mg IV as needed
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____