CONNALLY MEMORIAL MEDICAL CENTER

☐ **STAT REFERRAL**

ANTIBIOTIC ORDER FORM

CONNALLY MEMORIAL INFUSION CENTER
Phone: 830-477-0424 Fax: 1-877-249-1191

PATIENT INFORMATION (Required *)

*Last Name: _____ *First Name: _____ MI_____ *DOB:_____ HT:_____ WT:_____

Sex :( ) Male ( ) Female SSN:_____ Home#: _____ Cell#: _____

*Address _____ *City/State/Zip _____

Allergies: _____

*Primary Insurance Name _____ *Policy ID #: _____

Secondary Insurance Name _____ Policy ID #:_____

Physician Name _____ Contact Name _____ Contact Phone # _____

Address: _____ City/State/Zip_____

*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	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		
	Invanz (Ertapenem)	1000 mg	( ) IV ( ) IM		

SELECT	DRUG	DOSE	ROUTE	REPEAT EVERY	DURATION
	Merrem (Meropenem)	500 mg	( ) IV		
	Merrem (Meropenem)	1000 mg	( ) IV		
	Gentamicin (Garamycin)		( ) 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		

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:		

Physician's Signature _____ **Time**_____ **Date**_____

**Signature must be clear and legible with the time and date of signature for order to be processed*

Co-Signature (If Required)_____ **Time**_____ **Date**_____

**Signature must be clear and legible with the time and date of signature for order to be processed*

Fax completed form to the Outpatient Infusion Center at 1 (877) 249-1191.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.