SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

ANTIBIOTICS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

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

_____

Provider 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): ☐ DISCHARGE PICC AFTER LAST DOSE ☐ LINE CARE PER HOSPITAL PROTOCOL UNTIL LINE IS REMOVED

a) ALL MEDIPORTS/IV ACCESSES MAY BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

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)	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:				

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.