IV Antibiotics

Referring Physician Orders Rev. 3/2025

Please fax completed referral form & all required documents to 208-595-4427

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ _____, ICD10 _____ ☐ _____, ICD10 _____

INFUSION ORDERS

Antibiotics will be dispensed in an elastomeric device (ED) for administration unless specified otherwise or as required by insurance.

☐ Cefazolin _____ gm IV over 30 minutes q8hr via ED or ambulatory pump x _____ ☐ days ☐ weeks

☐ Cefepime _____ gm IV over 30 minutes q12hr via ED or ambulatory pump x _____ ☐ days ☐ weeks

☐ Ceftriaxone _____ gm IV over 30 minutes q24hr via ED, stationary or ambulatory pump x _____ ☐ days ☐ weeks

☐ Dalvance® IV over 30-60 minutes via stationary pump

- ☐ 1500 mg x 1 dose
- ☐ 1000 mg x 1 dose, followed one week later by 500 mg x 1 dose
- ☐ Other: _____

☐ Daptomycin IV over 30 minutes q24hr via ED or stationary pump x _____ ☐ days ☐ weeks

- ☐ 500 mg ☐ _____ mg

☐ Ertapenem 1 gm IV over 30 minutes q24hr via ED or stationary pump x _____ ☐ days ☐ weeks

☐ Kimyrsa® IV 2 hours via stationary pump

- ☐ 1200 mg x 1 dose
- ☐ Other: _____

☐ Meropenem IV over 30 minutes q ____ hr via ED pump x _____ ☐ days ☐ weeks

- ☐ 500 mg ☐ 1000 mg

☐ Vancomycin IV over 90 minutes q ____ hr via ED, stationary or ambulatory pump x _____ ☐ days ☐ weeks

- ☐ 1000 mg ☐ _____ mg
- Vancomycin trough levels before 4th dose, then weekly.

☐ Other: _____

☐ Other: _____

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

ADDITIONAL ORDERS: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

☐ Culture and sensitivity report

☐ For patients currently receiving vancomycin or aminoglycosides: most recent labs and drug trough level

☐ Other: _____