PARAGON HOME INFUSION

ANTIBIOTICS ORDER FORM

Phone: 866-972-5888
Fax: 866-491-5888

Patient Name: ____________________ DOB: __________ Sex: ☐ M ☐ F
Address: ____________________
City: __________ State: ______ Zip: ______ Phone: __________
☐ *Demographics Attached*

INSURANCE INFORMATION ☐ *copy of card(s) attached*

Primary Insurance: ____________________ Phone: __________
Cardholder Name: __________ ID# __________ Group# __________
Employer: __________ DOB: __________ Relationship: __________

Secondary Insurance: ____________________ Phone: __________
Cardholder Name: __________ ID# __________ Group# __________
Employer: __________ DOB: __________ Relationship: __________

MEDICAL INFORMATION

Primary Diagnosis: ____________________ ICD-9 Code: __________
Patient Weight: ______ lbs. Height: ______ Diabetic ☐ Yes ☐ No
Allergies: ____________________
Does patient already have a line? ☐ No ☐ Yes – type of line: __________
Has patient previously received this antibiotic? ☐ No ☐ Yes: __________
If No, can first dose be given at home? ☐ Yes ☐ No
☐ *Labs Attached*
If No, can we send the following as a precaution? ☐ Yes ☐ No
☐ Diphenhydramine 25-50 mg PO or IV prn allergic reaction
☐ Epinephrine 1:1000 subcut IM prn severe allergic reaction
☐ Other: __________

MEDICATION ORDERS

☐ Acyclovir
☐ Amikacin
☐ Amphotericin B
☐ Ampicillin/Sulbactam *(Unasyn)*
☐ Cefazolin
☐ Cefepime *(Maxipime)*
☐ Ceftazidime *(Fortaz)*
☐ Ceftriaxone *(Rocephin)*
☐ Cipro
☐ Clindamycin
☐ Cubicin
☐ Doribax
☐ Fluconazole
☐ Gentamicin
☐ Imipenem/Cilastatin *(Primaxin)*
☐ Invanz
☐ Levaquin
☐ Metronidazole *(Flagyl)*
☐ Merrem
☐ Mycamine
☐ Nafcillin
☐ Oxacillin
☐ Piperacillin/Tazobactam *(Zosyn)*
☐ Timentin
☐ Tobramycin
☐ Tygacil
☐ Vancomycin
☐ Vibativ
☐ Xerava
☐ *do not substitute*

☐ Other: ____________________
Dose: ______mg ______ grams ______mg/kg
Frequency: ☐ Daily ☐ Every 12 hours ☐ Every 8 hours ☐ Every ____ hours ☐ Other __________
Duration: ______ days ______ weeks
Flush Orders: ☐ Normal saline 1-20mL pre or post infusion prn ☐ D5W 1-20mL pre or post infusion prn
☐ Heparin 100 units per mL 1-5mL post infusion prn ☐ Heparin 10 units per mL 1-5mL post infusion prn

Nursing Services requested: ☐ Yes ☐ No

PHYSICIAN INFORMATION

Physician Name: __________ License # __________ NPI # __________
Phone: __________ Fax: __________ Nurse/Key Contact: __________
Physicians Signature: ____________________ Date: __________

© 2015, Paragon Healthcare, Inc.