

ANTIBIOTICS INFUSION ORDERS

PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

DIAGNOSIS:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cellulitis/MSSA
Location: _____ | <input type="checkbox"/> Diabetic Wound
Location: _____ | <input type="checkbox"/> MRSA
Location: _____ |
| <input type="checkbox"/> Chronic Bronchitis _____ | <input type="checkbox"/> Diverticulitis _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Chronic Sinusitis _____ | <input type="checkbox"/> Gastroenteritis _____ | <input type="checkbox"/> Complicated UTI _____ |
| <input type="checkbox"/> Dehydration/Flu/Viral
syndrome _____ | <input type="checkbox"/> Pyelonephritis _____ | <input type="checkbox"/> Osteomyelitis
Location: _____ |
| | <input type="checkbox"/> Other: _____ | |

ANTIBIOTIC IV ORDERS

- | | | |
|---|---|---|
| <input type="checkbox"/> Avelox 400mg | <input type="checkbox"/> Flagyl 500mg | <input type="checkbox"/> Primaxin <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg |
| <input type="checkbox"/> Baxdela <input type="checkbox"/> 300mg
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Fortaz <input type="checkbox"/> 1gm <input type="checkbox"/> 2gm | <input type="checkbox"/> Rocephin <input type="checkbox"/> 1gm <input type="checkbox"/> 2gm |
| <input type="checkbox"/> Cefazolin 1gm | <input type="checkbox"/> Gentamicin _____ mg | <input type="checkbox"/> Tobramycin _____ mg |
| <input type="checkbox"/> Cipro 400mg | <input type="checkbox"/> Invanz 1g | <input type="checkbox"/> Vancomycin (<i>must have PICC line</i>)
<input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg <input type="checkbox"/> _____mg |
| <input type="checkbox"/> Clindamycin _____ mg | <input type="checkbox"/> Levaquin _____ mg | *Vancomycin levels before 4 th dose then trough weekly. |
| <input type="checkbox"/> Cubicin
<input type="checkbox"/> 4mg/kg <input type="checkbox"/> 6mg/kg
<input type="checkbox"/> Baseline CPK and BMP | <input type="checkbox"/> Maxipime <input type="checkbox"/> 1gm <input type="checkbox"/> 2gm | <input type="checkbox"/> Zemdri <input type="checkbox"/> 15mg/kg (CrCl ≥ 90)
<input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dalvance
<input type="checkbox"/> 1000mg followed one week later by 500mg.
<input type="checkbox"/> 750mg followed one week later by 375mg (CrCl < 30)
<input type="checkbox"/> 1500mg x 1 dose
<input type="checkbox"/> 1125mg x 1 dose (CrCl < 30) | <input type="checkbox"/> Merrem _____ mg | *CrCl must be monitored daily* |
| | <input type="checkbox"/> Orbactiv 1200mg | <input type="checkbox"/> Zithromax 500mg |
| | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Zosyn 3. 375g |
- Lab Orders: _____
- Additional Orders/Comments: _____

DOSING Daily or BID
for _____ days _____ weeks

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATION

- | | | | | | | | | | |
|------------------------------------|---------------------------------|---------------------------------|----------------------------------|------------------------------------|--------------------------------------|--------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Arlington | <input type="checkbox"/> Austin | <input type="checkbox"/> Dallas | <input type="checkbox"/> Houston | <input type="checkbox"/> Knoxville | <input type="checkbox"/> North Hills | <input type="checkbox"/> Plano | <input type="checkbox"/> Round Rock | <input type="checkbox"/> San Antonio | <input type="checkbox"/> Stone Oak |
| P: 817.200.2530 | P: 512.261.4800 | P: 972.408.2777 | P: 713.860.1755 | P: 865-299-7525 | P: 817.284.2700 | P: 469-974-0565 | P: 737-443-5230 | P: 210.366.4358 | P: 210.485.3700 |
| F: 817.509.0011 | F: 512.261.4803 | F: 469.913.6894 | F: 713.277.7219 | F: 865-338-5604 | F: 817.284.2701 | F: 469-608-2072 | F: 737-402-7698 | F: 210.366.4896 | F: 210.390.1738 |

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