Antibiotic Orders

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to (903) 595-3788

Patient Name: _____ DOB: _____ Phone: _____

~~Patient~~ Status: ☐ New Therapy ☐ Continuation of Therapy Next Treatment Date: _____

Patient Weight: _____ lbs. (required) Patient Height: _____ Diabetic ☐ Yes ☐ No

Allergies: _____

Primary Diagnosis: _____ICD-10: _____

Does the patient have an IV line? ☐ Yes ☐ No – If yes, line type: ☐ PIV ☐ PICC ☐ Midline ☐ Port

THERAPY ORDER

☐ Cefazolin (Ancef)
☐ Cefepime (Maxipime)
☐ Ceftriaxone (Rocephin)
☐ Daptomycin (Cubicin)
☐ Ertapenem (Invanz)
☐ Other: _____
☐ Piperacillin/Tazbactam (Zosyn)
☐ Vancomycin

Dose: _____ mg _____ grams _____ mg/kg ☐ Do not substitute

Frequency: ☐ Daily ☐ Every 12 hours ☐ Every 8 hours ☐ One dose ☐ Continuous over 24 hours
☐ Every _____ hours ☐ Other: _____

Duration: _____ days _____ weeks **Route:** ☐ IV ☐ IM ☐ Other: _____

Other orders: _____

NURSING ORDER

Arrange nursing? ☐ Yes ☐ No - If nursing has already been arranged, agency name: _____
☐ RN to establish peripheral IV or use existing line and flush per orders
☐ RN to remove PICC/Midline at the end of therapy
Flush orders: ☐ NS 1-20mL pre/post infusion PRN ☐ Other: _____ 1-20mL pre/post infusion PRN
☐ Heparin 10U/mL: _____ ☐ Heparin 100U/mL: _____
Lab orders: _____ **Frequency:** ☐ Weekly ☐ Other: _____
Labs to be drawn by: ☐ Home Health Nurse ☐ Prescriber
Other orders: _____

REACTION KIT ORDERS

☐ Diphenhydramine 25-50mg PO or IV PRN allergic reaction (adult)

☐ Epinephrine 1:1000, 0.3mL IM PRN severe allergic reaction (adult)

Other orders: _____

PROVIDER INFORMATION

Provider Name: _____ Signature: _____
Date: _____ Provider NPI: _____
Phone: _____ Fax: _____
Contact Person: _____

Required Documentation

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING

Please fax all information to (903) 595-3788 or call (903) 592-8115 for assistance

☐ Signed and completed order (MD/prescriber to complete page 1)

☐ Patient demographic information

☐ Insurance information (copy of insurance card front and back)

☐ Patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis

☐ Labs results

☐ Culture results (if applicable)

☐ PICC/Central line placement confirmation (if applicable)

☐ Other medical necessity: _____

NuTech will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required.

Thank you for the referral