

General Antibiotic Referral Form



REQUIRED INFORMATION

This signed order form from the provider

Patient demographics and insurance information

Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)

Include any Culture and Sensitivity results if available

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis and ICD-10:		
Pharmacist to review medical records and labs and make drug therapy recommendations OR Drug: _____ Dose: _____ Frequency: Q6H Q8H Q12H Q24H Q48H Continuous over 24 hours x _____ days weeks		
Line Type: PIV Midline PICC Port Tunneled Catheter Other: _____ Line Placement: Patient will have line placed prior to discharge Burnham's Vital Care to schedule midline placement Catheter Maintenance: Pharmacy to provide all supplies needed to complete therapy as prescribed May use Burnham's Vital Care protocol for flushing and catheter maintenance May discontinue and pull line upon completion of therapy Other: _____ Home Health: _____ Burnham's Vital Care to arrange Home Health		
Labs Orders: CBC CMP CRP ESR Vancomycin Trough CPK (if on Daptomycin) Other: _____ to be drawn weekly and PRN when adjusting dose/therapy Pharmacist to manage labs and dosage		
Additional Instructions:		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

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