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:		