477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: ____

Date of Birth: ______________________ Weight: ___________

IV Access: ___________________________ Height:_________

Allergies: ____

Antibiotic Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

Diagnoses:

____ ICD-10: ________________________

____ ICD-10: ________________________

____ ICD-10: ________________________

Medication Orders:

- ◆ Medication/Dose:__________________________________ First dose? Yes❑ No❑ Route: ___________
  Instructions:______________________________________ Length of therapy/end date: __________
- ◆ Medication/Dose:__________________________________ First dose? Yes❑ No❑ Route: ___________
  Medication/Dose:__________________________________ First dose? Yes❑ No❑ Route: ___________
  Instructions:______________________________________ Length of therapy/end date: __________
- ❑ Clinical pharmacist to monitor drug levels and adjust dose accordingly.
- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- ❑ If no central IV access, RN to insert peripheral IV, rotate site as needed, and remove at end of therapy.
- ❑ Other: ____

Labs:

Lab		
❑ CBC with Diff	❑ weekly	❑ every ________________
❑ ESR (Erythrocyte Sedimentation Rate)	❑ weekly	❑ every ________________
❑ Serum Creatinine	❑ weekly	❑ every ________________
❑ ALT	❑ weekly	❑ every ________________
❑ CRP	❑ weekly	❑ every ________________
❑ CK (for Daptomycin)	❑ weekly	❑ every ________________
❑ BMP (Na, K, Cl, CO2, BUN, SCr, Gluc, Ca)	❑ weekly	❑ every ________________
❑ CMP (BMP + AST, ALT, TP, Alb, Glob, Alp, Tbil)	❑ weekly	❑ every ________________
❑ Hepatic Panel (Alk Phos, Alb, DBil, Tbil, TP, ALT, AST)	❑ weekly	❑ every ________________
❑ Other: ______________________________	❑ weekly	❑ every ________________

____ ________________________

Prescriber Signature *Date*

____

Please Print Name

KEY: ◆ Orders are initiated unless crossed out by provider. **❑ Check to initiate order.**

Form # 304
Updated 1/20/2025 -AF