Anti-Infectives Order Form
(Antibiotics, Antivirals, & Antifungals)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____ ☐ Home ☐ Clinic

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

ICD 10 Code: _____ Description: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Ordering providers will need to provide all baseline labs to initiate therapy.**

PRESCRIPTION

Initiation/Continuation of Infusion Therapy Orders

Standard Protocol
Flush IV access device with heparin/saline per Medix Infusion protocol
Weekly & PRN dressing changes for IV access
Per Medix Infusion protocol, an ANA kit which includes 50 mg of Diphenhydramine oral solution will be dispensed to home infusion patients.

Select All That Apply
☐ Place PICC line for medication administration
☐ Patient has pacemaker (may verify PICC line placement with CXR)
☐ Patient will need a first dose and teaching

Lab Orders
CBC, CMP, ESR, CRP weekly
Other: _____ Frequency: _____
Other: _____ Frequency: _____
Daptomycin: CPK weekly
Vancomycin trough: 30 minutes prior to 4th dose and then weekly thereafter
<< Medix Infusion pharmacists will manage dosage according to PI and lab results>>

DRUG	DOSE	ROUTE	FREQUENCY	DURATION

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____