ANTIBIOTIC REFERRAL FORM

vitalcare of the FOUR STATES
109 E Hickory St., Neosho, MO 64850
417-451-7900 / 877-370-4246
FAX: 417-451-7915

Patient Name: _____ DOB: _____

Address, City, State, ZIP: _____

Pt Wt: _____ Pt Ht: _____ Pt Allergies: _____

Diagnosis: _____

Medications:

☐ Daptomycin _____ MG _____ DAILY

☐ Ertapenem (Invanz) ___ G _____ DAILY

☐ Meropenem (Merrem) _____ G EVERY _____ HOURS

☐ Ceftriaxone (Rocephin) _____ G / DAILY

☐ Cefazolin (Ancef) _____ G EVERY _____ HOURS

☐ Cefepime (Maxipime) _____ MG _____ DAILY

☐ Piperacillin/Tazobactam (Zosyn) _____ MG EVERY _____ HOURS

☐ _____

Duration: _____

IV access: Administer medication through:

☐ Midline ☐ PICC ☐ Subcutaneous Port

Patient scheduled for ML or PICC placement at _____

on _____ 20___

IV Maintenance Protocol:

☒ Dispense necessary flushes per pharmacy protocol

☐ Weekly dressing changes and/or PRN

Labs:

☐ CBC w/diff ☐ CMP ☐ CRP ☐ ESR ☐ CK ☐ BMP ☐ _____

FAX RESULTS: _____

Physician / APRN Signature _____ Date _____

Physician Name/NPI/PRINT _____

Address: _____