ABSOLUT CARE PHARMACY
10119 Broadway St.
San Antonio TX 78217
(210) 310-3060 P
(210) 310-3209 F

INFUSION CENTER LOCATION
10119 BROADWAY ST.
SAN ANTONIO TX 78217

ANTIBIOTICS INFUSION ORDERS

PATIENT INFORMATION

☐ *DEMOGRAPHICS ATTACHED*

PATIENT NAME: _____ DOB: _____ PHONE: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

PATIENT WEIGHT: _____ LBS (REQUIRED) ALLERGIES: _____

☐ Clinical/Progress Notes, Labs (bmp), Tests supporting primary diagnosis attached

LABS: REQUIRED TO BE DRAWN BY ☐ INFUSION CLINIC ☐ REFERRING PHYSICIAN

LAB ORDERS: _____

DIAGNOSIS: *Please Indicate ICD-10*

- ☐ Cellulitis/MSSA Location: _____
- ☐ Chronic Bronchitis _____
- ☐ Chronic Sinusitis _____
- ☐ Dehydration/Flu/Viral Syndrome _____
- ☐ Diabetic Wound Location: _____
- ☐ Diverticulitis _____
- ☐ Gastroenteritis _____
- ☐ Pyelonephritis _____
- ☐ Other: _____
- ☐ MRSA Location: _____
- ☐ Pneumonia _____
- ☐ Complicated UTI _____
- ☐ Osteomyelitis Location: _____

ANTIBIOTIC IV ORDERS

- ☐ Avelox/Moxifloxacin
- ☐ Baxdela/Delafloxacin Meglumine
- ☐ Cefazolin 1gm
- ☐ Cipro 400mg
- ☐ Clindamycin _____ mg
- ☐ Cubicin
  - ☐ 4mg/kg ☐ 6mg/kg
  - Baseline CPK and BMP
- ☐ Flagyl 500/Metronidazole
- ☐ Fortaz/Ceftazidime ☐ 1gm ☐ 2gm
- ☐ Gentamicin _____ mg
- ☐ Invanz 1gm/ertapenum
- ☐ Levaquin/Levofloxacin
- ☐ Maxipime/Cefepime ☐ 1gm ☐ 2gm
- ☐ Merrem/Meropenem _____ mg
- ☐ Other: _____
- ☐ Primaxin/Imipenem-cilastatin ☐ 250mg ☐ 500mg
- ☐ Rocephin/Ceftriaxone ☐ 1gm ☐ 2gm
- ☐ Tobramycin _____ mg
- ☐ Vancomycin (must have PICC line)
  - ☐ 500mg ☐ 1000mg _____ mg
  - ***Vancomycin levels before 4th dose then trough weekly***
- ☐ Xerava _____ mg
- ☐ Zemdri
  - ☐ 15mg/kg (CrCl ≥ 90)
  - ☐ Other:
  - ***CrCl must be monitored daily***
- ☐ Zithromax/Azithromycin
- ☐ Zosyn 3.375g/Piperacillin-Tazobaetam

DOSING ☐ Daily or ☐ BID

for _____ days _____ weeks

☐ Additional Orders: _____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing AbsolutCare Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME: _____ CONTACT PERSON: _____

PHONE: _____ FAX: _____

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