HealthQuest
Infusion & Specialty

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T 832.612.3500 F 866.612.3437

ANTIBIOTICS REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE _____ DATE NEEDED _____

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____ E-mail _____
Date of Birth _____ SS # _____
☐ Female
☐ Male

Prescriber's Name _____
License # _____ DEA # _____
NPI # _____ UPIN # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

ANTIBIOTIC ORDER

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

PRIMARY DIAGNOSIS: _____ **ICD-10 CODE:** _____

Is patient diabetic? ☐ Yes ☐ No **Does patient already have a line?** ☐ Yes ☐ No **Type of line:** _____

Has patient previously received this antibiotic? ☐ Yes ☐ No

— If No, can first dose be given at home? ☐ Yes ☐ No **— If No, can we send the following as a precaution?** ☐ Yes ☐ No

☐ Diphenhydramine 25–50mg PO or IV pm allergic reaction
☐ Epinephrine 1:1000 subcut IM pro severe allergic reaction

☐ *Labs attached*
☐ Other: _____

MEDICATION ORDER

☐ Acyclovir®
☐ Amykacin®
☐ Amphotericin B®
☐ Ampicillin/Sulbactam® (Unasyn)
☐ Cefazolin®
☐ Cefepime® (Maxipime)
☐ Ceftazidime® (Fortaz)
☐ Ceftriaxone® (Rocephin)
☐ Cipro®
☐ Clindamycin®
☐ Cubicin® (Daptomycin)
☐ Dalvance®
☐ Doribax®
☐ Fluconazole®
☐ Gentamicin®
☐ Imipenem/Cilastatin® (Primaxin)
☐ Invanz®
☐ Levaquin®
☐ Metronidazole® (Flagyl)
☐ Merrem®
☐ Mycamine®
☐ Nafcillin®
☐ Orbactiv®
☐ Oxacillin®
☐ Piperacillin/Tazobactam® (Zosyn)
☐ Timentin®
☐ Tobramycin®
☐ Tygacil®
☐ Vancomycin®
☐ Zyvox® (Linezolid)

☐ ***Do not substitute***

☐ Other: _____

Dose: _____ mg _____ grams _____ mg/kg

Frequency: ☐ Daily ☐ Every 12hrs ☐ Every 8hrs ☐ Every 6hrs ☐ Every 4hrs ☐ Continuous over 24hrs

Duration: _____ Weeks _____ Days

Flush Orders: ☐ Normal Saline 1–20mL pre or post infusion prn ☐ D5W 1–20mL pre or post infusion prn
☐ Heparin 10 units per mL 1–5mL post infusion prn ☐ Heparin 100 units per mL 1–5mL post infusion prn

Labs: ☐ CBC w/Diff ☐ CMP ☐ CRP ☐ ECR ☐ ESR ☐ SCR ☐ Vanco peak _____ ☐ Vanco trough _____ ☐ Other: _____

How often? _____

Check the following: ☐ PICC Line/Mid Line/Peripheral IV Insertion ☐ X-Ray for PICC Line Placement
☐ Home Health Asssessment and/or Skilled Nursing ☐ Remove "line" after therapy completed

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____