BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

ANTIBIOTIC ORDERS

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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ANTIBIOTIC ORDERS

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Height: Weight: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last infusion:

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS

☐ Dx Code and description:

REQUIRED DOCUMENTATION

☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

PRESCRIBING INFORMATION

LAB ORDERS-to be drawn by ☐ **Home Health Nurse** ☐ **Prescriber**

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other:

MEDICATION

Medication	Dose	Route/Frequency	Duration	
☐ **Cefazolin (Ancef)**		IV Every hours	X days	X weeks
☐ **Cefepime (Maxipime)**		IV Every hours	X days	X weeks
☐ **Ceftriaxone (Rocephin)**		IV Every hours	X days	X weeks
☐ **Daptomycin (Cubicin)**		IV Every hours	X days	X weeks
☐ **Ertapenem (Invanz)**		IV Every hours	X days	X weeks
☐ **Meropenem (Merrem)**		IV Every hours	X days	X weeks
☐ **Nafcillin (Unipen)**		IV Every hours	X days	X weeks
☐ **Piperacillin/Tazobactam (Zosyn)**		IV Every hours	X days	X weeks
☐ **Vancomycin**		IV Every hours	X days	X weeks
☐ **Other:**		IV Every hours	X days	X weeks

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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