ISLAND INFUSION CENTER

1015 25th Street Building, Upper Level
Anacortes, WA, 98221

Phone: 360.299.4200
Fax: 360.299.4237

PROVIDER ORDER FORM

Antibiotic Infusions

- Please complete form and fax with latest clinical documentation to 360.299.4237
- Include latest lab results

Patient Name (First, Middle, Last): _____ D.O.B. _____

Height: _____ ☐ cm ☐ in Weight:_____ ☐ kg ☐ lbs Allergies: _____

Diagnosis: _____ ICD-10 Code: _____

Pre-auth Done? ☐ Not required ☐ Yes Authorization #: _____ Authorization Dates: _____

Start date_____Stop date_____

Lab Orders:

☐ CBC and CMP_____times/week ☐ CRP_____times/week

☐ CK_____ times/week ☐ ESR_____times/week

Medication Orders:

☐ Ceftriaxone ☐ 1 gm or ☐ 2 gm IV once daily for _____ days/_____ weeks

☐ Ertapenem ☐ 0.5 gm or ☐ 1 gm IV once daily for_____ days/_____ weeks

☐ Daptomycin _____ mg/kg (_____ mg) IV once daily for _____ days/_____ weeks

☐ Other: _____

Nursing Orders:

☐ Central Line care per Infusion Center. ☐ Remove PICC line after last dose.

☐ If no central IV line, nurse to insert a peripheral IV to be rotated at least every 72 hours.

☐ In case of infusion reaction, RN management will be carried out per Island Health Policy as needed.

Other:_____

_____

PROVIDER SIGNATURE	DATE
PRINT PROVIDER NAME	*PROVIDER EMERGENCY PHONE #

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