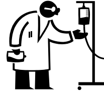

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

IV ANTIBIOTIC ORDERS

******Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ________________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis:____

ICD-10 : __________________________, _________________________, ______________________________

LABS to be drawn:

- ☐ **NONE**
- ☐ CBC
- ☐ PT, PTT
- ☐ BMP
- ☐ CMP
- ☐ CK/CPK
- ☐ Urinalysis
- ☐ Other: __________________________________

Frequency:

- ☐ Weekly
- ☐ Monthly
- ☐ Trough / Peak (for Aminoglycosides)
- ☐ Other: ________________________________

☐ Pharmacist to Dose

Antibiotic Name and Dose:____

Frequency and Duration: ____

Start Date of Infusion: _____/_____/_____ **End Date of Infusion**: _____/_____/_____

Other Orders: ____

____

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: ________________________ **Fax Number:** _______________________________________