

Antibiotic Referral Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION

Please include ALL clinical/office notes, lab results, H&P related to therapy and list of current medications/allergies.

Patient Name:	Date of Birth:	Phone:
Patient Weight:	Patient Allergies:	

INSURANCE INFORMATION Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)

Diagnosis:	ICD-10
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PRESCRIPTION INFORMATION All necessary supplies will be provided as needed

Start Date of Therapy:

Medication	Dose/Route/Directions	Duration	Quantity
	_____ mg IV every ____ hours	for ____ days	# QS
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☐ Check if pharmacy is to clinically manage Vancomycin dosing

IV Access type: ☐ Peripheral ☐ PICC line ☐ Port ☐ CVAD (Central Venous Access Device) ☐ Admit to Home Health Agency

Anaphylaxis orders: (Nursing to call MD if patient has anaphylactic reaction)

☐ Epinephrine ☐ 1:1000 0.3mL IM as needed for anaphylaxis, and ☐ Diphenhydramine ☐ 25-50 mg IM as needed for anaphylaxis
☐ Sodium Chloride 0.9% ☐ mL IV to provide fluid as needed
☐ Other: _____

IV access flushing and line care orders:

☐ Heparin ☐ 10 units/ml Flush line with 3-5 ml after last saline flush and into unused IV line if needed ☐ 100 units/ml
☐ Sodium chloride 0.9% Flush line with 5-10 ml before and after each dose of medication infused and into unused IV line if needed
☐ Other: _____

☐ Nurse orders:

Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

LAB TESTS:

☐ CBC with DIFF ☐ CMP ☐ BMP ☐ ESP ☐ Other labs like CPK ☐ No Labs

Physician Information

Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI #:	Specialty:	
Address:	City:	State:	Zip:
Nurse Contact:	Phone:	Fax:	
Physician Signature:		Date:	

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

