Antimicrobials

Order Form
Rev. 4/12/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ◉ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

☐ *(required)* **Culture and susceptibility results were attached.**

☐ *(required)* **Recent lab results were attached.**

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

LAB ORDERS

Collect: ☐ BMP ☐ CMP ☐ CBC w/ diff ☐ CBC w/o diff ☐ CRP ☐ ESR ☐ CK ☐ _____

Lab Frequency: ◉ Daily ◉ Weekly ◉ _____

THERAPY ADMINISTRATION

Antimicrobial IV

Medication: _____

☐**Infusion Associates provider to dose medication and order labs.**

Dose: _____

Frequency: ◉ Daily ◉ Every OTHER day

Total number of doses or end date of treatment: _____

Does the patient have a PICC in place? ◉ Yes ◉ No

Remove PICC on the last day of treatment? ○ Yes ○ No

Date of last infusion if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**