Comanche County Memorial Hospital

Outpatient Infusion Center Antibiotics Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- ☐ Fax front/back of insurance card
- ☐ Fax clinical/progress notes
- ☐ Fax labs
- ☐ Fax patient demographics
- ☐ Fax current medication list
- ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- ☐ DX: _____
- ☐ DX: _____
- ☐ DX: _____

Clinical Information:

- ☐ New Therapy Induction
- ☐ Therapy Change
- ☐ Therapy Continuation
- ☐ Patient Weight: _____ lbs/ _____ kg
- ☐ Patient Height: _____ in/ _____ cm
- ☐ Allergies: _____
- ☐ Therapies Tried and Failed: _____
- ☐ TB Test: Date: _____ Results: _____
- ☐ Hep B Test: Date: _____ Results: _____
- ☐ Does the patient have venous access? Yes or No
  If No, initiate IV access.
  If yes, What type? _____

Lab Orders

- ☐ CBC w/o diff ☐ CMP ☐ ESR ☐ CRP
- ☐ Other: _____

Lab Orders to be done by

- ☐ Infusion Services
- ☐ Referring Provider

Prescription Information

- ☐ Medication _____ ☐ Dose: _____ ☐ Frequency: _____ Rate: _____
- ☐ Medication _____ ☐ Dose: _____ ☐ Frequency: _____ Rate: _____
- ☐ Medication _____ ☐ Dose: _____ ☐ Frequency: _____ Rate: _____

Misc Orders

- ☐ _____
- ☐ _____
- ☐ PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- ☐ 10mL NS Flush Syringe PRN
- ☐ Heparin 500units/5mL Flush Syringe PRN
- ☐ 50ml NS Bag PRN
- ☐ 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- ☐ Stop infusion and initiate NS bolus
- ☐ Notify Supervising physician and ordering provider
- ☐ Solu-Cortef 100mg SIVP signs of adverse reaction
- ☐ Benadryl 25 mg SIVP for hives or bronchial inflammation
- ☐ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- ☐ Oxygen 2-5L nasal cannula
- ☐ Albuterol 2.5mg inhaled PRN to chest tightness
- ☐ Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time