IV ANTIBIOTICS ORDER

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Labs: _____

ANTIBIOTIC INFORMATION

Antibiotic Name and Dose:_____

Frequency and Duration:_____

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

Other Orders or Special Instructions:_____

_____

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994