Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ________________________________ Patient D.O.B.___________________________

Current Height: ____________________________ Current Weight___________________________

Patient Phone # (______) _______-________________ Gender_______________________

Patient Address ____

City_________________ State _______________ Zip Code_________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (______) _______-________________ Office Contact: ____________________________

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Antimicrobial Treatment Plan

Patient Name: ________________________________ **Patient DOB** __________________________

General

☐ Diagnosis- __________________ ICD-10:________________

Pt. Weight _____________ Pt Height _____________ Known Allergies _____________

Requested Start Date ____/____/_______ Requested Stop Date ____/____/_______

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_______

☑ Vital Signs (Month 1 to 12)
Resp, BP, HR, Temperature prior to infusion and prior to discharge

** **Please note:** Only antimicrobial orders with an administration frequency of *DAILY* will be accepted in CMC outpatient infusion services. Infusion orders for every 12 hours, every 8 hour, etc. regimens should be directed to a home infusion provider. Patients with orders for daily antimicrobial treatment should have established IV access prior to arrival.

Pre-Treatment Medications

Tylenol

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before infusion

Benadryl

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before infusion

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before infusion

SOLU-Medrol

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before infusion

Antimicrobial Therapy

☐ **Amikacin**

_____________ mg ☐ Daily ☐ M / W /F
(*Note: Ordering provider responsible for level monitoring and dose adjusmtents and subsequent order changes. Inpatient pharmacy may be contacted for dose adjustment recommendations but will **NOT** take verbal orders for dose adjusmtents)

☐ **Ceftriaxone (Rocephin®)**

☐ 1000mg daily ☐ 2000mg daily

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ________________________ Provider Name (please print)________________________

Date_____/_____/_________ Patient Name ____________________________ Patient DOB______________

Antimicrobial Treatment Plan

☐ **Dalbavancin (Dalvance®)**
- ☐ 1500mg as a single IV dose
- ☐ 1000mg as a single IV dose followed by 500mg weekly
- ☐ 1500mg as a single IV dose followed by 1000mg every other week

☐ **Daptomycin (Cubicin®)** (*Note: Pharmacy will dose on adjusted BW for patients with BMI >35. All doses will be rounded to nearest 50 mg)
- ☐ 4mg/kg daily ☐ 6mg/kg daily ☐ 8mg/kg daily ☐ 10 mg/kg daily

☐ **Ertapenem (Invanz®)**
- ☐ 500mg daily ☐ 1000mg daily

☐ **Levofloxacin (Levaquin®)**
- ☐ 500mg daily ☐ 750mg daily

☐ **Vancomycin**

______________ mg ☐ Daily ☐ M / W /F

(*Note: Ordering provider responsible for level monitoring and dose adjusmtents and subsequent order changes. Inpatient pharmacy may be contacted for dose adjustment recommendations but will **NOT** take verbal orders for dose adjusmtents)

☐ **Fluconazole (Diflucan®)**
- ☐ 200mg daily ☐ 400mg daily ☐ 800mg daily ☐ Other __________mg daily

☐ **Micafungin (Micamine®)**
- ☐ 100mg daily ☐ 150mg daily

**** Note: All antimicrobial orders will be prepared in accordinance with institutional standardized base fluids (ie normal saline, D5W, etc.), concentrations, and infusion times.**

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs

☐ Vancomycin Tough Level
*To be drawn every _________ days

☐ CBC w/ Diff
*To be drawn every _________ days

☐ AST / ALT
*To be drawn every _________ days

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _________________________ Provider Name (please print)_________________________

Date_____/_____/_________ Patient Name ____________________________ Patient DOB_______________

Antimicrobial Treatment Plan

- ☐ Urinalysis with Microscopic
  *To be drawn every __________ days
- ☐ Sedimentation Rate
  *To be drawn every __________ days
- ☐ C-Reactive Protein
  *To be drawn every __________ days
- ☐ BUN
  *To be drawn every __________ days
- ☐ Creatinine w/GFR
  *To be drawn every __________ days
- ☐ Lipid Panel
  *To be drawn every __________ days for
- ☐ Creatine phosphokinase (CPK)
  *To be drawn every __________ days
- ☐ CMP
  *To be drawn every __________ days
- ☐ Amikacin Trough Level
  *To be drawn 60 min prior to Amikacin dose every __________ days
- ☐ Amikacin Peak Level
  *To be drawn 30 min after Amikacin dose every __________ days

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ___________________________ Provider Name (please print)___________________________

Date_____/_____/__________ Patient Name ______________________________ Patient DOB________________