FirstHealth OF THE CAROLINAS

7096.08.16137.01 Sunset Date: 6/2024

OP Antibiotics Referral

3POREF001

Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 06/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
☐ Moore Regional Hospital (MRH)
☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until _____

Nursing Orders	Interval	Duration
☐ Insert peripheral IV Once	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous Once	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once 500 Units, intravenous Once	_____	_____
Nursing Communication		
☐ Nursing communication Once	_____	_____
☐ Discharge instructions Once OK to discharge patient after infusion is complete	_____	_____

Provider Signature: _____ Date: _____ Time: _____

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PICC Line Removal	Interval	Duration
☐ Discontinue PICC line after Therapy Plan is completed	_____	_____
Pre-Medications		
☐ dextrose 5 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, For 1 Dose Carrier Fluid	_____	_____
☐ sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, For 1 Dose Carrier Fluid	_____	_____
Labs		
☐ CBC with auto differential	_____	_____
☐ BUN	_____	_____
☐ Creatinine, serum	_____	_____
☐ CK	_____	_____
☐ Comprehensive metabolic panel	_____	_____
☐ Sedimentation Rate	_____	_____
☐ AST	_____	_____
☐ ALT	_____	_____
☐ Bilirubin, total	_____	_____
☐ Vancomycin, trough	_____	_____
Cefazolin		
☐ ceFAZolin (ANCEF) 2 g in sodium chloride 0.9 % 100 mL IVPB 2 g, intravenous, for 30 Minutes	_____	_____
Ceftriaxone		
☐ cefTRIAXone (ROCEPHIN) 1 g in sodium chloride 0.9 % 50 mL IVPB 1 g, intravenous, for 30 Minutes	_____	_____
☐ cefTRIAXone (ROCEPHIN) 2 g in sodium chloride 0.9 % 50 mL IVPB 2 g, intravenous, for 30 Minutes	_____	_____
Daptomycin		
☐ DAPTOmycin (CUBICIN) 4 mg/kg in sodium chloride 0.9 % 50 mL IVPB 4 mg/kg, intravenous, for 30 Minutes The infusion line should be flushed before and after each administration with normal saline.	_____	_____
☐ DAPTOmycin (CUBICIN) 6 mg/kg in sodium chloride 0.9 % 50 mL IVPB 6 mg/kg, intravenous, for 30 Minutes The infusion line should be flushed before and after each administration with normal saline.	_____	_____
Dalbavancin		
☐ dalbavancin (DALVANCE) 500 mg in dextrose 5 % 250 mL IVPB	_____	_____

Provider Signature: _____ **Date:** _____ **Time:** _____

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500 mg, intravenous, for 30 Minutes
Flush line before and after administration with D5W solution

☐ dalbavancin (DALVANCE) 1,000 mg in dextrose 5 % 250 mL IVPB _____ _____
1,000 mg, intravenous, for 30 Minutes
Flush line before and after administration with D5W solution

☐ dalbavancin (DALVANCE) 1,500 mg in dextrose 5 % 250 mL IVPB _____ _____
1,500 mg, intravenous, for 30 Minutes
Flush line before and after administration with D5W solution

Ertapenem **Interval** **Duration**

☐ ertapenem (INVanz) 1 g in sodium chloride 0.9 % 50 mL IVPB _____ _____
1 g, intravenous, for 30 Minutes

Vancomycin

☐ vancomycin (VANCOCIN) IV 15 mg/kg (Treatment Plan) _____ _____
15 mg/kg, intravenous

☐ vancomycin (VANCOCIN) IV 20 mg/kg (Treatment Plan) _____ _____
20 mg/kg, intravenous

Oritavancin

☐ oritavancin (ORBACTIV) 1,200 mg in dextrose 5 % 1,000 mL IVPB _____ _____
1,200 mg, intravenous, for 3 Hours

Micafungin

☐ micafungin (MYCAMINE) in sodium chloride 0.9 % 100 mL IVPB _____ _____
intravenous, for 60 Minutes

PRN Medications

☐ diphenhydrAMINE (BENADRYL) capsule 25 mg _____ _____
25 mg, oral, For 1 Dose

☐ diphenhydrAMINE (BENADRYL) injection 25 mg _____ _____
25 mg, intravenous, For 1 Dose

☐ acetaminophen (TYLENOL) tablet 650 mg _____ _____
650 mg, oral, For 1 Dose

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

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