



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____

Allergies: _____

Antibiotic Order Form

◆ **Orders are initiated unless crossed out by provider.**

Check box to initiate order.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses: _____ ICD-9: _____
 _____ ICD-9: _____
 _____ ICD-9: _____

Medication Orders:

- Medication/Dose: _____ Route: _____
 Instructions: _____ Estimated length of therapy: _____ TBD
- Medication/Dose: _____ Route: _____
 Instructions: _____ Estimated length of therapy: _____ TBD
- Medication/Dose: _____ Route: _____
 Instructions: _____ Estimated length of therapy: _____ TBD
- Clinical pharmacist to monitor drug levels and adjust dose accordingly
- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.
- Other: _____

Labs:

- | | | |
|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> CBC with Diff | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> ESR (Erythrocyte Sedimentation Rate) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> SCr (Serum Creatinine) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> ALT | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CPK (for Daptomycin) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> BMP (Na, K, Cl, CO2, BUN, SCr, Gluc, Ca) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CMP (BMP + AST, ALT, TP, Alb, Glob, Alp, Tbil) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Hepatic Panel (Alk Phos, Alb, DBil, Tbil, TP, ALT, AST) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |

Prescriber Signature

Date

Please Print Name