AYSA
THERAPEUTICS INFUSION CENTER

ANTIBIOTICS ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

DIAGNOSIS: ***Please indicate ICD-10***

☐ Cellulitis/MSSA Location: _____
☐ Chronic Bronchitis _____
☐ Chronic Sinusitis _____
☐ Dehydration/Flu/Viral Syndrome _____
☐ Diabetic Wound Location: _____
☐ Diverticulitis _____
☐ Gastroenteritis _____
☐ Pyelonephritis _____
☐ MRSA Location: _____
☐ Pneumonia _____
☐ Complicated UTI _____
☐ Osteomyelitis Location: _____
☐ Other: _____

ANTIBIOTIC IV ORDER

☐ Avelox 400mg
☐ Avycaz 2.5 grams
CrCl daily if CrCl <50mL/min
☐ Baxdela ☐ 300mg
☐ Other: _____
☐ Cefazolin 1gm
☐ Cipro 400mg
☐ Clindamycin _____ mg
☐ Cubicin
☐ 4mg/kg ☐ 6mg/kg
☐ Baseline CPK and BMP
☐ Dalvance
☐ 1000mg followed one week later by 500mg.
☐ 750 mg followed one week later by 375mg (CrCl < 30)
☐ 1500 mg x 1 dose
☐ 1125 mg x 1 dose (CrCl < 30)

☐ Flagyl 500mg
☐ Fortaz ☐ 1gm ☐ 2gm
☐ Gentamicin _____ mg
☐ Invanz 1g
☐ Kimyrsa 1200mg x 1 dose
☐ Levaquin _____ mg
☐ Maxipime ☐ 1gm ☐ 2gm
☐ Merrem _____ mg
☐ Nuzyra ☐ 200mg ☐ 100mg
☐ Orbactiv 1200mg x 1 dose
☐ Other: _____
_____

☐ Primaxin ☐ 250mg ☐ 500mg
☐ Rocephin ☐ 1gm ☐ 2gm
☐ Tobramycin _____ mg
☐ Vancomycin (must have PICC line)
☐ 500mg ☐ 1000mg ☐ _____ mg
*Vancomycin levels before 4th dose then trough weekly
☐ Vibativ ☐ 10mg/kg
☐ Other: _____
☐ Xerava _____ mg
☐ Zemdri ☐ 15mg/kg (CrCl ≥ 90)
☐ Other: _____
CrCl must be monitored daily
☐ Zerbaxa ☐ 1.5 grams ☐ 3 grams
☐ Other: _____
CrCl daily as indicated
☐ Zithromax 500mg
☐ Zosyn 3.375g

DOSING ☐ Daily or ☐ BID
for _____ days _____ weeks

☐ Lab Orders: _____
☐ Additional Orders/Comments: _____
_____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____