BIG SKY MANAGED CARE Rx INFUSION

Antibiotics Order Form

Phone: 406-315-1989
Fax: 406-315-1988

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Sex: ☐ M ☐ F

MEDICAL INFORMATION

Primary Diagnosis: _____ Diabetic: ☐ Yes ☐ No

Allergies: _____

Does patient already have a line? ☐ No ☐ Yes – Type of line: _____

Has patient previously received this antibiotic? ☐ No ☐ Yes: _____

If No, can first dose be given at home? ☐ Yes ☐ No

☐ *Labs Attached*

If No, can we send the following as a precaution? ☐ Yes ☐ No

☐ Diphenhydramine 25-50 mg PO or IV prn allergic reaction

☐ Epinephrine 1:1000 subcut IM prn severe allergic reaction

☐ Other: _____

MEDICATION ORDERS

□ Acyclovir	□ Ceftriaxone (Rocephin)	□ Imipenem/Cilastatin (Primaxin)	□ Piperacillin/Tazobactam (Zosyn)
□ Amikacin	□ Cipro	□ Invanz	□ Timentin
□ Amphotericin B	□ Clindamycin	□ Levaquin	□ Tobramycin
□ Ampicillin/Sulbactam (Unasyn)	□ Cubicin	□ Metronidazole (Flagyl)	□ Tygacil
□ Cefazolin	□ Doribax	□ Merrem	□ Vancomycin
□ Cefepime (Maxipime)	□ Fluconazole	□ Mycamine	□ Vibativ
□ Ceftazidime (Fortaz)	□ Gentamicin	□ Nafcillin	□ Xerava
□ Other _____		□ Oxacillin	□ do not substitute

Dose: _____mg _____ grams _____ mg/kg

Frequency: ☐ Daily ☐ Every 12 hours ☐ Every 8 hours ☐ Every ____ hours ☐ Other _____

Duration: _____days _____ weeks

Flush Orders: ☐ Normal Saline 1-20mL pre or post infusion prn ☐ D5W 1-20 mL pre or post infusion prn

☐ Heparin 100 units per mL 1-5mL post infusion prn ☐ Heparin 10 units per mL 1-5mL post infusion prn

Nursing Services Requested: ☐ No ☐ Yes

Physician Name: _____ Date: _____

Physician Signature: _____