Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

IV Antibiotic Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Please attach culture results

Labs to be collected: ☐ CMP ☐ BMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CRP ☐ ESR ☐ CK ☐ Other: _____

Lab Frequency: ☐ Daily ☐ Weekly ☐ Other:_____

☐Pharmacist to Dose

IV Antibiotic Name:_____

Dose: _____

Frequency: ☐ Daily ☐ Every OTHER day ☐ Other:_____

Total number of doses or end date of treatment: _____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____