Infusion ASSOCIATES

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

Orbactiv IV Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and 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 and susceptibility results

What medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use	Reason for discontinuation

Labs to be collected: ☐ CMP ☐ BMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CBC w/man diff ☐ Other: _____

Lab Frequency: ☐ Every infusion ☐ Other:_____

☐Pharmacist to Dose

Orbactiv (oritavancin) IV:

Dose: ☐ 1200 mg x1 dose
☐ Other:_____

Printed Provider Name: _____

Provider Signature: _____

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