



Phone: (833) 394-0600 Fax: (833) 996-4888

Daptomycin 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?

Drug	Dose	Dates of use	Reason for discontinuation

Is patient taking a statin? No Yes, but instructed to hold during treatment with daptomycin

Labs to be collected: CMP BMP CBCw/o diff CBC w/diff CBC w/man diff CRP ESR CPK _____

Lab Frequency: Every infusion Weekly

Pharmacist to dose medication and order labs

Daptomycin IV

Dose: _____ mg _____ mg/kg

Frequency: Daily Every OTHER day

Total number of doses or end date of treatment: _____

Does patient have a PICC in place? YES NO

Remove PICC on last day of treatment? YES NO

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____

Contact Name: _____ Contact Phone Number: _____

New referring providers, how did you hear about us? Web Search Pharma Rep Drug Locator Patient
 Word of Mouth IA Clinical Liaison IA Website Facebook Instagram Other: _____