Infusion ASSOCIATES®

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

Ceftriaxone 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

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

Lab Frequency: ☐ Daily ☐ Weekly ☐ _____

☐ Infusion Associates provider to dose medication and order labs

Ceftriaxone IV

Dose: ☐ 1 gram ☐ 2 grams ☐ _____

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: _____