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

Dalbavancin 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 ☐ CBC w/man diff ☐CRP ☐ESR ☐ _______

Lab Frequency: ☐ Every infusion ☐ _______________

☐ Infusion Associates provider to dose antibiotic and order labs

Dalvance (dalbavancin) IV

☐ 1500 mg x1dose

☐ 1000 mg day 1 and 500 mg day 8 for 2 total doses

☐ ___________mg given q__________ for __________total doses

☐ ____

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: _______________