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

□ Infusion Associates provider 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: _____