

**Touchstone Infusion**

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INFECTIOUS DISEASE: BACTERIAL

Date: _____ Needs by Date: _____

Ship to: ☐ Patient ☐ Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
Phone: _____ Alt Phone: _____
Social Security # _____
Date of Birth _____ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name: _____
Contact Person: _____
DEA: _____ NPI: _____
Address: _____
Phone: _____ Fax: _____

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK ☐ RECENT LABS (w/ cultures if available) ☐ PICC LINE VERIFICATION

CLINICAL INFORMATION

INDICATION: ☐ Cellulitis ☐ Pneumonia ☐ UTI ☐ Osteomyelitis ☐ Intraabdominal ☐ Bloodstream/Septicemia ☐ Other: _____

VASCULAR ACCESS: ☐ Peripheral Line ☐ Mid line ☐ Central Line/Port ☐ PICC: number of lumens _____

PICC LINE INSTRUCTIONS (Please select one) ☐ D/C PICC after last dose ☐ Perform line care per pharmacy protocol until line is removed.

☐ All IV accesses may be flushed with saline and/or heparin per Touchstone protocol following SASH method ☐ MD Specific Flush Protocol Specify: _____

Drug Allergies: _____

Height: _____ ☐ in ☐ cm
Weight: _____ ☐ kg ☐ lbs

Labs (if available): Culture ☐ Blood ☐ Urine ☐ Skin ☐ Other: _____ Date Performed: _____ Findings: _____

Last Creatinine (if available): _____ umol/L Date of Sample _____ or CrCL _____ Date of Sample _____ (Creatinine required for drug level monitoring)

PRESCRIPTION INFORMATION

Medication	Dose	Route	Frequency	Duration	Other Notes/Directions (if needed)	Ancillary Orders
☐ Ciprofloxacin	☐ 200mg ☐ 400mg	IV	☐ q24h ☐ q12h ☐ q8h ☐ q6h ☐ q4h ☐ Other _____			<i>All orders include Supplies/Pump/Pole as appropriate to administer ordered therapy. Please put additional orders regarding supplies below.</i> ☐ Anaphylaxis Kit- EpiPen Auto Injector use as directed. 2 Pak Kit PRN, refill x1 year ☐ Dressing Changes ☐ Weekly ☐ Other: _____ ☐ Laboratory Orders (Every _____) ☐ BMP ☐ CMP ☐ CBC w/ diff ☐ BUN/CREATININE ☐ ESR ☐ VANC TROUGH ☐ GENT TROUGH ☐ CRP ☐ CPK ☐ ☐
☐ Clindamycin	☐ 300mg ☐ 600mg ☐ 900mg ☐ 1200mg					
☐ Dalvance (dalbavancin)	☐ 500mg ☐ 1000mg ☐ 1500mg ☐ Other: _____					
☐ Daptomycin	☐ _____ mg/kg/dose ☐ 500mg					
☐ Imipenem-Cilastatin	☐ 500mg ☐ 1000mg					
☐ Invanz (ertapenem)	☐ 500mg ☐ 1000mg ☐ Other: _____ (____ mg/kg)					
☐ Levofloxacin	☐ 250mg ☐ 500mg ☐ 750mg					
☐ Maxipime (cefepime)	☐ 1 gram ☐ 2 gram ☐ Other: _____ (____ mg/kg)					
☐ Merrem (meropenem)	☐ 500mg ☐ 1gram ☐ 2grams ☐ Other: _____ (____ mg/kg)					
☐ Rocephin (ceftriaxone)	☐ 1 gram ☐ 2 grams ☐ Other: _____ (____ mg/kg)					
☐ Vancomycin	☐ 500mg ☐ 750mg ☐ 1000mg ☐ 1500mg ☐ 2000mg ☐ Other: _____ (____ mg/kg)					
☐ Zosyn (piperacillin/tazobactam)	☐ 2.25 grams ☐ 3.375 grams ☐ Other: _____					
☐ Other: _____						

Start of Home Therapy: _____	Last Dose in Hospital: Date: _____ Time: _____	Home Health Preference: ☐ Pharmacy to Select ☐ _____
End of Home Therapy: _____	*Please administer first dose in hospital if possible	

By signing this form and utilizing our services, you are authorizing Touchstone Infusion and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps)

Substitution Permitted

DAW

Date