Touchstone Infusion
9101 Lakeview Parkway Ste. 500
Rowlett, TX 75088
P: (469) 925-1010 F: (877) 257-0305

INFECTIOUS DISEASE: BACTERIAL

Date: _____ Needs by Date: _____ Ship to: □ Patient □ Office □ Other _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Contact Person: _____
Phone: _____ Alt Phone: _____	DEA: _____ NPI: _____
Social Security # _____	Address: _____
Date of Birth _____ □ Male □ Female	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 wtih 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)
□ Ciprofloxacin	□200mg □400mg	IV	□ q24h □ q12h □ q8h □ q6h □ q4h □ Other _____		
□ 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: _____					

Ancillary Orders

All orders include Supplies/Pump/Pole as appropriate to administer ordered therapy. Please put additional orders regarding supplies below.

□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
- □
- □

Start of Home Therapy: _____

End of Home Therapy: _____

Last Dose in Hospital:
Date:_____ Time:_____
**Please administer first dose in hospital if possible*

Home Health Preference:
□Pharmacy to Select
□_____

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