Wasatch INFUSION

888.717.7578 801.577.7055

Open 365 days a year • 8am-8pm

BY APPOINTMENT

ANTIBIOTICS ORDER FORM

LOCATION

☐ Murray ☐ Tooele

REFERRAL STATUS

☐ New Referral ☐ Order Renewal

PATIENT INFORMATION

PATIENT NAME:	DOB: SEX: ☐ M: ☐ F:
WEIGHT: ☐ LBS ☐ KG	PHONE #:
ALLERGIES:	EMAIL:

Please check that the following are included:

- ○ Patient demographics and insurance attached
- ○ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
- ○ Current Medication List

DIAGNOSIS

ICD-10 CODE:	Other:	Date of last infusion/injection:

PHYSICIAN INFORMATION

Physician Name:	Phone Number:
Practice Name:	Fax Number:
Office Contact:	

MEDICATION ORDER

Medication:	Dosing:	Frequency:	Notes/Comments

Physician Signature _____ Date (Order is Valid for One Year) _____

LAB ORDERS

☐ CMP ☐ CBC ☐ CRP ☐ ESR ☐ Other_____

☐ Labs to be Drawn by Infusion Center Frequency: _____ Standing Order? ☐ Yes ☐ No

TYPE OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ Subcu ☐ I/M