

IV Antibiotics Order



Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics Insurance Information Current Lab Results
 H & P Relevant to the Diagnosis Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

ANTIBIOTIC INFORMATION

Antibiotic Name and Dose: _____

Frequency and Duration: _____

Start Date of Infusion: ____ / ____ / ____ End Date of Infusion: ____ / ____ / ____

Other Orders or Special Instructions: _____
