BEAUMONT INFUSION CENTERS

ANTIBIOTIC PRESCRIPTION

Location / Fax Number ☐ **Royal Oak : 248- 551-3168** ☐ **Troy : 248-964-2409** ☐ **Lenox : 947-523-4061** ☐ **Wayne : 734-467-2505** ☐ **Grosse Pointe : 586-498-4497** ☐ **Farmington Hills : 248-471-8217** ☐ **Dearborn : 313-593-5802** ☐ **Livonia : 734-542-3356**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Address:**	**Office #:**
Diagnosis:		**Diagnosis Code (ICD-10):**

Please attach these *required* documents to Prescription (if not in EPIC):

- Copy of Insurance Card
- Labs
- Supporting clinical documentation
- Patient Demographics

☐ **NKDA** ☐ **Drug Allergies:** ____

Height: ______ ft _______ in **Weight:** __________ kg / lbs **Date:** ________________________

☐ **PICC LINE MAINTENANCE**

- Flush PICC line with 10cc NS per protocol
- Change PICC line dressing every 7 days per protocol

☐ Discontinue PICC line on day of last antibiotic infusion
☐ Continue PICC line care every 7 days after antibiotic infusion completed

LABS:

- CBC with Diff weekly for all antibiotics
- BUN/Cr twice weekly for aminoglycosides, once weekly for Vancomycin, and a CMP weekly for all other antibiotics.
- CK weekly for Daptomycin
- Vancomycin trough level weekly if on Vanco

☐ ____

Reaction Orders:

- Notify physician AND Adult Standard Anaphylaxis Protocol

DRUG	**DOSE**	**Total # Doses (or STOP Date)**
DAPTOMYCIN (CUBICIN)	☐ 4mg/kg ☐ 6mg/kg **OR** ☐ 8 mg/kg (rounded to the nearest 50mg) IV over 30 minutes **every** ☐ 24 hours **OR** ☐ 48 hours ***NOTE: Use adjusted body weight if BMI ≥ 30 kg/m²**	
ERTAPENEM (INVANZ)	☐ 1 gram **OR** ☐ 500mg IV over 30 minutes every 24 hours	
CEFEPIME (MAXIPIME)	☐ 500mg ☐ 1 gram ☐ 2 grams IV over 30 minutes **every** ☐ 12 hours ☐ 24 hours	
CEFTRIAXONE (ROCEPHIN)	☐ 1 gram **OR** ☐ 2 grams IV over 30 minutes **every** ☐ 12 hours ☐ 24 hours	
AMIKACIN	☐ Pharmacy to Dose **OR** ☐ _________________ (rounded to the nearest 50mg) IV every ☐ 24 hours ☐ 48 hours	
☐ GENTAMYCIN ☐ TOBRAMYCIN	☐ Pharmacy to Dose **OR** ☐ _________________ (rounded to the nearest 20mg) IV every ☐ 24 hours ☐ 48 hours	
VANCOMYCIN	☐ Pharmacy to Dose **OR** ☐ _________________ (rounded to the nearest 250mg) IV every ☐ 24 hours ☐ 48 hours	
DALBAVANCIN (DALVANCE)	☐ Single Dose Regimen: ☐ 1500 mg IV ONCE **OR** ☐ 1125 mg IV over 30 minutes ☐ Two-Dose Regimen Loading Dose: ☐ 1000 mg IV **OR** ☐ 750 mg IV over 30 minutes Seven Days after initial dose: ☐ 500 mg IV **OR** ☐ 375 mg IV over 30 min	
ORITAVANCIN (ORBACTIV)	☐ 1200 mg IV over 3 hours	**One Only**

Physician Signature ______________________________ **Beeper #**________________ **Date** ______________**Time**__________