# **Antibiotic** Referral Form

KabaFusion
Patient-Focused Infusion Therapy

**Wallingford, CT** **Fax Completed Form To: 203.456.2387** **Phone: 888.209.4691**

## PATIENT INFORMATION

***Please include ALL clinical/office notes, lab results, H&P related to therapy and list of current medications/allergies.***

| | | |
|---|---|---|
| Patient Name: | DOB: | Referral Date: |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ❑ Male ❑ Female |

## INSURANCE INFORMATION *Please attach FRONT and BACK copy of all insurance cards (Prescription and Medical)*

Patient Diagnosis & ICD-10:

Allergies:

## PRESCRIPTION INFORMATION *All necessary supplies will be provided as needed*

**Start Date of Therapy:**

| Medication | Dose/Route/Directions | Duration | Quantity |
|---|---|---|---|
| ❑ Ampicillin | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Ampicillin-sulbactam | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Cefazolin | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Cefepime | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Ceftazidime | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Ceftriaxone | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Daptomycin | _____ mg/kg IV every _____ hours | for _____ days | # QS |
| ❑ Ertapenem | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Gentamicin | _____ mg/kg IV every _____ hours | for _____ days | # QS |
| ❑ Imipenem cilastatin | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Meropenem | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Nafcillin | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Penicillin G potassium | _____ IV units / Day | for _____ days | # QS |
| ❑ Piperacillin-tazobactam | _____ gm IV every _____ hours | for _____ days | # QS |
| ❑ Tobramycin | _____ mg/kg IV every _____ hours | for _____ days | # QS |
| ❑ Vancomycin | _____ gm IV every _____ hours | for _____ days | # QS |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | NPI #: | Specialty: |
| Address: | City: | State & Zip: |
| Nurse Contact: | Phone: | Fax: |
| Physician Signature: | | Date: |
| | | |

***Prescriber's Signature*** ***Print Name*** ***Date***
***Dispense as Written***

***Prescriber's Signature*** ***Print Name*** ***Date***
***Substitution Permitted***