Antibiotic Referral Form

KabaFusion
Patient-Focused Infusion Therapy

Syracuse, NY **Fax Completed Form To: 315.469.9744** **Phone: 877.234.6400**

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