



Antibiotic Order Form

Patient Name: _____ DOB: _____

Drug name:		
Dose:		
Frequency:		
Expected duration:		
Lab orders (<i>all patients who have a duration of therapy > 7 days should receive weekly labs—CBC w/diff, BMP, and any pertinent drug levels are suggested</i>):		
Physician following labs:		
Fax labs to:		
Has patient received 1st dose (<i>if no, see next line</i>):	Yes	No
Please provide ANA Kit for 1st dose in home (<i>if above answer is no</i>)		
Has patient received ID consult:	Yes	No
Dose administration times:		
Please provide PICC care per protocol		
Expected date PICC line pulled or attached order:		
Expected date of facility discharge:		
Additional needs (<i>wound care, PT, OT, ST, etc</i>):		

Provider Signature: _____ Date: _____

DHCH CCC Checklist:

- ✓ Check Epic for patient info (including hospital consults)
- ✓ Send information to DHCH-Infusion Referrals@duke.edu (Rx, demos, recent labs, insurance, etc)
- ✓ Benefits Verification/Quote Costs (notify team of agreement)
- ✓ Confirm RN agency and SOC date
- ✓ Confirm method of administration
- ✓ Confirm teaching arrangements
- ✓ Confirm all orders present (Rx, wound care, PT, ST, OT, etc)
- ✓ Confirm facility discharge date and delivery plan