Anti-Infective Therapy
PRESCRIPTION & ENROLLMENT FORM

Referral date ______________

❑ New patient
❑ Current patient

1 PATIENT INFORMATION

Items in bold are required.

Patient's name ____________________

Date of birth __________ ❑ **Male** ❑ **Female** **Social Security number** __________

Allergies ____________________

Street address ____________________ Apt # __________

City ____________________ **State** __________ **ZIP** __________

Parent/guardian (if applicable) ____________________

Primary phone __________ Secondary phone __________

E-mail address ____________________

Emergency contact ____________________

Relationship __________ Phone __________

Employer ____________________

Primary insurance company ____________________

Insurance company phone ____________________

Policy holder name ____________________

Date of birth __________ Relationship to patient __________

Policy/group # __________ **Identification #** __________

Drug card company ____________________

Drug card company phone ____________________

RxBIN # __________ PCN # __________ Person code __________

Policy/Group # ____________________

Secondary insurance company ____________________

Insurance company phone ____________________

Policy holder name ____________________

Date of birth __________ Relationship to patient __________

Policy/group # __________ **Identification #** __________

Please attach copy(s) of front and back of patient's insurance card(s) , if available.

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Prescriber name and title ____________________

Clinic/hospital affiliation ____________________

Office contact ____________________

Street address ____________________ Suite # __________

City ____________________ State __________ ZIP __________

Phone __________ Fax __________

NPI # __________ License # __________

UPIN # __________ DEA # __________

Referral source (check one) ❑ Prescriber ❑ Patient self-referral ❑ No referring MD

❑ Referring MD (if different from prescriber) ____________________

Date __________ Time __________

Name and title of person faxing this form ____________________

3 ANTI-INFECTIVE PRESCRIPTION INFORMATION

Diagnosis ____________________

Drug ____________________ Dose __________

Frequency __________ Duration __________

Drug 2 (if necessary) ____________________ Dose __________

Frequency __________ Duration __________

❑ First dose
- ❑ Diphenhydramine 50-mg prefilled syringe
- ❑ *EpiPen®* Auto-Injector 0.3 mg/0.3 mL ❑ *EpiPen Jr.®* Auto-Injector 0.15 mg/0.3 mL

❑ Dispense DME and ancillary supplies as needed to facilitate drug administration

Labs: ❑ CBC ❑ Other ____________________

Frequency of labs: ❑ Weekly ❑ Other ____________________

IV access (check one)
- ❑ Peripheral ❑ Midline ❑ PICC ❑ Other __________

Flush orders
- ❑ Normal saline 1–20 mL preinfusion or postinfusion prn
- ❑ D5W 1–20 mL preinfusion or postinfusion prn
- ❑ Heparin 100 units per mL 1–5 mL postinfusion prn
- ❑ Heparin 10 units per mL 1–5 postinfusion prn
- ❑ Other ____________________

❑ Nursing

Registered Nurse to conduct initial visit to assess patient and venous access, provide training on antibiotic infusion therapy and applicable supplies/DME, and assess response to therapy.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's printed name ____________________

Prescriber's signature (sign below) **Date** __________

__________ __________

Dispense as written **Substitution allowed**

(Prescriber attests this is his/her legal signature. **NO STAMPS**)

Address 1:
Address 2:
Phone:

Please fax completed form to:

Critical Care Systems will contact the patient and/or physician's office for additional information as needed.

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