



# Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

## Antimicrobial Therapy

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.

Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: \_\_\_/\_\_\_/\_\_\_

Site of Service:  TH Muskegon  TH Shelby

Referral Status:  New Referral  Dose or Frequency Change  Renewal

<b>Patient Name:</b> _____ <b>Date of Birth:</b> ___/___/___ <b>Weight:</b> ___ kg <b>Height:</b> ___ cm <b>Allergies:</b> _____	<b>Primary Insurance:</b> _____ <b>Member ID:</b> _____ <b>Secondary Insurance:</b> _____ <b>Member ID:</b> _____
<p style="text-align: center;"><b>Diagnosis</b></p> <b>Diagnosis Code (ICD-10):</b> _____ <b>Indication:</b> _____ <b>Target start date:</b> _____	<p style="text-align: center;"><b>Lab Orders</b></p> <input type="checkbox"/> AST/ALT <input type="checkbox"/> BMP <input type="checkbox"/> BUN <input type="checkbox"/> CBC <input type="checkbox"/> CBC + Diff <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> CK <input type="checkbox"/> Creatinine (serum) <input type="checkbox"/> Sed rate <input type="checkbox"/> Other: _____
<p style="text-align: center;"><b>Frequency</b></p> <input type="checkbox"/> Daily <input type="checkbox"/> Weekly (Mon) <input type="checkbox"/> Once <input type="checkbox"/> Other: _____	
<p><b>Pre-medications:</b> No pre-medications are routinely given. Pre-medications may be ordered at physician discretion.</p> <input type="checkbox"/> Other: _____	
<p><b>Rx Antimicrobial Therapy:</b></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Cefepime _____ g IVP [Max Once Daily Dosing]  <input type="checkbox"/> Ceftriaxone _____ g IVP  <input type="checkbox"/> Daptomycin _____ mg IVPB  <input type="checkbox"/> Ertapenem _____ g IVPB  <input type="checkbox"/> Miconazole _____ g IVPB           </div> <div style="width: 45%;"> <input type="checkbox"/> Pen. G benzathine (Bicillin-LA) _____ mill units IM  <input type="checkbox"/> Dalbavancin _____ mg IVPB  <input type="checkbox"/> Rezafungin: _____ mg IVPB  <input type="checkbox"/> Other: _____           </div> </div> <p><b>Frequency:</b></p> <input type="checkbox"/> Once <input type="checkbox"/> Daily x ___ days <input type="checkbox"/> Weekly x ___ dose(s) <input type="checkbox"/> Other schedule: _____	
<p><b>Nursing Orders:</b></p> <p><b>Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:</b></p> <p>sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN; meperidine injection 25 mg</p>	
<b>Provider Name:</b> _____ <b>Office Phone Number:</b> _____ <b>Attending Physician Name:</b> _____ <small>(If ordering provider is an advanced practice practitioner, attending physician name required)</small> <small>Note: This order is valid for 12 months from date of physician signature.</small>	<b>Provider Signature:</b> _____ <b>Office Fax Number:</b> _____