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

Patient Name: ___________________________________
Date of Birth: ____/____/____
Weight: _____kg **Height:** _____cm
Allergies: _____________________________________

Primary Insurance: ____________________________
Member ID: ____________________________________
Secondary Insurance: ___________________________
Member ID: ____________________________________

Diagnosis

Diagnosis Code (ICD-10): _________________________
Indication: ______________________________________
Target start date: _________________________________

Lab Orders

☐ AST/ALT ☐ BMP ☐ BUN ☐ CBC ☐ CBC + Diff ☐ CMP
☐ CRP ☐ CK ☐ Creatinine (serum) ☐ Sed rate
☐ Other: _____________________________________

Frequency

☐ Daily ☐ Weekly (Mon) ☐ Once
☐ Other: _____________________________________

Pre-medications: No pre-medications are routinely given. Pre-medications may be ordered at physician discretion.
☐ Other: ____

℞ Antimicrobial Therapy:

☐ Cefepime ________ g IVP [Max Once Daily Dosing]
☐ Ceftriaxone ______ g IVP
☐ Daptomycin ______ mg IVPB
☐ Ertapenem ______ g IVPB
☐ Micafungin ______ g IVPB
☐ Pen. G benzathine (Bicillin-LA) _____ mill units IM
☐ Dalbavancin _____ mg IVPB
☐ Rezafungin: ________ mg IVPB
☐ Other: ______________________________________

Frequency:

☐ Once ☐ Daily x ___ days ☐ Weekly x ___dose(s) ☐ Other schedule: __________________

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:

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

Provider Name: _________________________________
Office Phone Number: ___________________________
Attending Physician Name: ______________________
Provider Signature: ___________________________________
Office Fax Number: ___________________________________

(If ordering provider is an advanced practice practitioner, attending physician name required)
Note: This order is valid for 12 months from date of physician signature.