



Jupiter Infusion
140 Jupiter Lakes Blvd, Suite A
Jupiter, FL 33458
Office: 561-277-9211

IV Antibiotics Order Form

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Height: _____ Diabetic Yes No

Allergies: _____

Primary Diagnosis: _____ ICD-10 Code: _____

THERAPY ORDER

- | | | |
|--|---|--|
| <input type="checkbox"/> Acyclovir | <input type="checkbox"/> Dalvance | <input type="checkbox"/> Orbactiv |
| <input type="checkbox"/> Amikacin | <input type="checkbox"/> Doribax | <input type="checkbox"/> Oxacillin |
| <input type="checkbox"/> Amphotericin B | <input type="checkbox"/> Fluconazole | <input type="checkbox"/> Piperacillin/Tazobactam (Zosyn) |
| <input type="checkbox"/> Ampicillin/Sulbactam (Unasyn) | <input type="checkbox"/> Gentamicin | <input type="checkbox"/> Teflaro |
| <input type="checkbox"/> Avycaz | <input type="checkbox"/> Imipenem/Cilastatin (Primaxin) | <input type="checkbox"/> Tigecycline |
| <input type="checkbox"/> Cefazolin | <input type="checkbox"/> Invanz | <input type="checkbox"/> Timentin |
| <input type="checkbox"/> Cefepime (Maxipime) | <input type="checkbox"/> Kimyrsa | <input type="checkbox"/> Tobramycin |
| <input type="checkbox"/> Ceftazidime (Fortaz) | <input type="checkbox"/> Levaquin | <input type="checkbox"/> Tygacil |
| <input type="checkbox"/> Ceftriaxone (Rocephin) | <input type="checkbox"/> Metronidazole (Flagyl) | <input type="checkbox"/> Vancomycin |
| <input type="checkbox"/> Cipro | <input type="checkbox"/> Merrem | <input type="checkbox"/> Vibativ |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Mycamine | <input type="checkbox"/> Xerava |
| <input type="checkbox"/> Cubicin | <input type="checkbox"/> Nafcillin | |

Other: _____ Do not substitute

Dose: _____ mg _____ grams _____ mg/kg

Frequency: One Dose Daily Every _____ days Other: _____

Duration: _____ days _____ weeks Route: IV IM Other: _____

Flush orders: NS 1-20mL pre/post infusion PRN D5W 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____