ENT REFERRAL FORM

FAMILY PHARMACY VITAL CARE
1720 Hillcrest Drive
Vernon, TX 76384
Phone 940-552-2999 • Fax 940-552-5347

Patient Name: _____ DOB: _____

Pt Wt: _____ Pt Ht: _____ Pt Allergies: _____

*Please attach Demographics page, relevant Labs, History & Physical or Progress Note, and Medications List

Diagnosis: _____

Medications:

- ☐ Cefazolin (Ancef) 2 grams IV every 8 hours
- ☐ Cefepime (Maxipime) 1 gram IV every 12 hours
- ☐ Ceftazidime (Fortaz) 2 grams IV every 8 hours
- ☐ Ceftriaxone (Rocephin) 2 grams IV every 24 hours
- ☐ Meropenem (Merrem) 1 gram IV every 8 hours
- ☐ Piperacillin/tazobactam (Zosyn) 4.5 grams IV every 8 hours
- ☐ Daptomycin (Cubicin) 6 mg/kg IV every 24 hours
- ☐ Vancomycin IV – pharmacy to dose and manage kinetics
- ☐ Methylprednisolone (Solu-Medrol) 40 mg IV every 24 hours

Duration: _____ Quantity (#QS): _____

End date of labs, medication, IV access: _____

IV access:

Place and administer medication through:

☐ Peripheral IV ☐ Midline ☐ PICC

Anaphylaxis Protocol:

☐ Anaphylaxis kit per pharmacy protocol

IV Maintenance Protocol:

☐ Dispense necessary flushes per pharmacy protocol

☐ Maintain IV access per Home health or pharmacy protocol

Labs:

☐ CBC w/diff ☐ CMP ☐ CRP ☐ ESR ☐ CPK ☐ BMP ☐ _____

Labs to be drawn on _____ then weekly thereafter

_____ _____ _____
Date Time Signature

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