PHYSICIAN REFERRAL FORM

NOTE: DISPENSING OF GENERIC FORMULATION IS AUTHORIZED UNLESS "BRAND MEDICALLY NECESSARY" IS INDICATED

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:

- ☐ Daptomycin (Cubicin) 6 mg/kg IV every 24 hours
- ☐ Vancomycin IV - Pharmacy to dose and manage kinetics
- ☐ Vibativ 10 mg/kg IV every 24 hours
- ☐ Dalvance 1500 mg IV once
- ☐ Orbactiv 1200 mg IV once
- ☐ Ceftriaxone 2 grams 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