

Edward Cancer Centers

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/527-3788 Fax: 630/548-6617

24600 West 127th Street; Plainfield, IL 60585
Phone: 630/527-3788 Fax: 630/548-6617

IV Antibiotic Standing Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

**Pre-Authorization # or
Call Reference #:** _____

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

**Contact Name and Phone Number
of Insurance Company:** _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Allergies: _____

Diagnosis (ICD 10 Required): _____

Patient's Weight (lbs/kg): _____ Patient's Height: _____

Drug Name: _____ Dosage: _____

Frequency: _____ Length of Treatment: _____

PICC Line: Yes No

Culture and Sensitivities, please include (if available) _____

Lab Orders: _____

Additional Orders: _____

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Edward Hospital NPI:** 1427069632

Physician Name (Please Print) **Office Phone** **Fax Number**