

Once Completed, FAX these orders to 309-624-8870 prior to discharge

Patient may be discharged when OK with primary service. Please contact primary service for all other discharge orders

Diagnoses for which ID was consulted

Patient was discharged to (**circle one**): Home Out patient infusion/ Nursing Home _____

Name of Pharmacy providing home antibiotic infusions _____

Name of Home Health Agency _____

Routine central line care for (**circle one**): N/A PICC Groshong Broviac Hickman Mediport

May use above central line to obtain weekly labs **Yes/No**

May institute Cathflo per protocol for OSF Home Health agencies and OSF Home Infusion Pharmacy **Y/N**

Labs at discharge: Creat _____ Bun _____ Vanco tr _____ Hgb _____ WBC _____ Other lab _____

Antibiotic/Antifungal/Antiviral orders

Drug	Dose	Frequency	Route	Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Labs (Please circle all that apply) to be done weekly on Mondays or _____ starting ____/____/____

CBC with Diff CMP/BMP ESR CRP CPK Vanco trough (draw 30 mins prior to dose) **Trough range to be** _____ to _____

Other lab _____

Other orders : (Nurses please schedule any testing prior to discharge and list date, time, and location)

Please call 309 624-8749 to schedule an appointment with Dr. _____ in _____ weeks

Physician signature

Date

Once orders completed must fax form to ID office 309 624-8870

Discharge Nurse Signature

Date