

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information
- List of Medications
- Tried & Failed Therapies
- Most Recent History & Physical
- Recent Lab Cultures

MEDICATION ORDER

Orbactiv® (Oritavancin) 1200mg IV in 1000ml **D5W** over 3 hours

*Flush with **D5W** before and after infusion

OTHER: _____

*Use only **D5W** for dilution and flushing, as NS is not compatible with Orbactiv®

REFILLS: _____

Patient to be observed for 30 minutes following the any administration. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN