

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):		_____	
Is the patient pregnant, planning a pregnancy or nursing:	Yes	No	Does the patient need interpreter services: Yes No

**Provider Information**

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip:

**ICD-10 CODE**

A49.1 Streptococcal infection	A49.01 Staphylococcus infection, methicillin susceptible
A49.02 Staphylococcus infection, methicillin resistant	A49.8 Other bacterial infections
Other: _____	

**Medication Order**

<b>Dalvance</b> (dalbavancin)	Single Dose Regimen:	Two Dose Regimen:
	1500mg IV	1000mg IV followed one week later by 500mg IV
	1125mg IV	750mg IV followed one week later by 375mg IV

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

<b>Provider Name</b>	<b>Provider Signature</b>	<b>Date</b>
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Order Expiration Date (mm/dd/yy): \_\_\_\_\_ (If not indicated order will expire one year from date signature) Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG G35, G36.0
BASIC METABOLIC PANEL I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA G35, G36.0
CALCIUM M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE G35, G36.0
CBC (INCLUDES DIFF/PLT) I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE M81.0, M81.8, G35	PSA R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP) R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR Z79.01, I48.91, I48.0, Z51.81
FERRITIN D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE E22, C7A.1, E34	TSH E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)
HIV 4TH GEN Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	
HIV 1/2 AB DIFF Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	

**Frequency**

Prior to each dose	Yearly	Other: Please Specify Below
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	

Provider Name	Provider Signature	Date
Provider Phone		
o 888.209.8874    aleracare.com	advanced infusion centers™	