NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk ▪ Portsmouth ▪ Scarborough ▪ Topsham
Phone: 207-303-3225 Fax: 207-692-2473

Daptomycin, Ceftriaxone, Ertapenem, Vancomycin, Amikacin

Patient Name:____ **DOB:**_________________

Diagnosis: ____ Diagnosis Code:_______________

Height: _____(cm) Actual Weight: ____(kg) Allergies: _________________________________

☐ Daptomycin IV: Dose:__________ Frequency:_______ Duration:________

☐ Vancomycin IV: Dose:__________ Frequency:_______ Duration:________

☐ Ertapenem IV: Dose:___________ Frequency:_______ Duration:________

☐ Ceftriaxone IV: Dose:___________ Frequency:________ Duration:________

☐ Amikacin IV: Dose:___________ Frequency:________ Duration:________

☐ Micafungin IV: Dose:____________ Frequency:________ Duration:________

☐ Cefepime IV: Dose:_____________ Frequency:_______ Duration:_______

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: ____

Provider Signature: ____ Date: ___________

Phone: _______________ Fax: _______________ Pager: _______________