Birmingham ID & Infusion

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DALVANCE (Dalbavancin) Infusion Order

Patient Name _____ DOB _____

Phone _____ Patient Weight _____ Height _____

***Please attach demographics, clinic notes and labs.**

DIAGNOSIS (Please provide ICD-10 code):

_____ Cellulitis _____ Osteomyelitis _____ _____ (Other)

PRE-MEDICATION (If needed):

_____ Tylenol 1,000 mg PO _____ Solu-Cortef 100 mg IVP

_____ Pepcid 20mg IV PRN _____ Benadryl 50mg PRN _____ _____

ORDERS/DOSAGE:

_____ 1,500 mg IV One Dose

PHYSICIAN NOTES: _____

ORDERING PROVIDER (Print Name): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____