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PHYSICIAN'S ORDER SHEET

**ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT
AFTER EACH ORDER IS PROPERLY CHECKED, FAX ORDER SHEET
TO PHARMACY WHETHER OR NOT ORDERS INVOLVE MEDICATION.**

PATIENT IDENTIFICATION	Check (✓) Each Order As Transcribed <input type="checkbox"/>	Check (✓) Pharmacy Orders <input type="checkbox"/>	Allergy _____
			DATE: _____ TIME: _____ (Military Time)
	VANCOMYCIN ORDER SHEET All Vancomycin Orders will be AUTOMATICALLY DISCONTINUED IN 72 HOURS		
	PLEASE LIST INDICATION FOR VANCOMYCIN BY CHECKING APPROPRIATE BOX		
	<input type="checkbox"/> For treatment of confirmed gram-positive infections in patients with serious beta-lactam allergies -or- confirmed infections with beta-lactam resistant organisms.		
	<input type="checkbox"/> For treatment of antibiotic-induced colitis with is unresponsive to metronidazole -or- severe life threatening disease.		
	<input type="checkbox"/> For AHA recommended endocarditis prophylaxis in high risk patients. (24 hr usage)		
	<input type="checkbox"/> For prophylaxis for major surgical procedures involving prosthetics. (24 hr usage)		
<input type="checkbox"/> For infections where beta-lactam resistant organisms are suspected -or- in patients with suspected gram positive infections with beta-lactam allergies.			
PLEASE CHECK THE APPROPRIATE BOXES FOR DOSE, ROUTE & FREQUENCY			
(IV Vancomycin dosing should reflect age and renal function. See formula below) Calculate creatinine clearance by the following method: $ClCr = \frac{(140 - \text{age}) \times (\text{IBW in kg})}{(72 \times \text{serum Cr.})}$ Multiply result by 0.85 for female patients For ClCr > 60 mls / minute: 1 gm IV every 12 hours For ClCr 40 - 59 mls / minute: 1 gm IV every 16 hours For ClCr < 40 mls / minute: 1 gm IV every 24 hours For Dialysis Patients: 1 gm IV every week -or- when trough level < 10 The above dosing suggestions are based on population kinetics and should be modified as dictated by appropriately drawn levels. [Draw peak 1 hour after infusing 3rd dose (infusion time = 1 hr), and draw trough 30 minutes before 4th dose. Repeat as often as renal function changes, or at least once weekly].			
VANCOMYCIN <input type="checkbox"/> 1 gram <input type="checkbox"/> I V <input type="checkbox"/> every 12 Hours <input type="checkbox"/> 750 mg <input type="checkbox"/> P O <input type="checkbox"/> every 24 Hours <input type="checkbox"/> 500 mg <input type="checkbox"/> x 1 dose <input type="checkbox"/> 250 mg <input type="checkbox"/> other: (describe below)			
FAXED BY/TIME: _____	TIME NOTED: _____	Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____ Date _____	

Military Time >>

PERMANENT PART OF THE CHART
USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD