**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.

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**DATE:**

**TIME:**

**VANCOMYCIN ORDER SHEET**

All Vancomycin Orders will be AUTOMATICALLY DISCONTINUED IN 72 HOURS

PLEASE LIST INDICATION FOR VANCOMYCIN BY CHECKING APPROPRIATE BOX

- For treatment of confirmed gram-positive infections in patients with serious beta-lactam allergies - or - confirmed infections with beta-lactam resistant organisms.
- For treatment of antibiotic-induced colitis with is unresponsive to metronidazole - or - severe life threatening disease.
- For AHA recommended endocarditis prophylaxis in high risk patients.  (24 hr usage)
- For prophylaxis for major surgical procedures involving prosthetics.  (24 hr usage)
- 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:

\[
\text{ClCr} = \frac{(140 - \text{age}) \times (\text{IBW in kg})}{(72 \times \text{serum Cr.})} 
\]

- 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**

- 1 gram
- 750 mg
- 500 mg
- 250 mg
- IV
- PO
- every 12 Hours
- every 24 Hours
- x 1 dose
- other: (describe below)

**FAXED BY/TIME:**

**TIME NOTED:**

Doctor's Signature _____________________________, MD Date __________

Nurse’s Signature / Title _____________________________ Date __________

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**PERMANENT PART OF THE CHART**

USE BALL POINT PEN ONLY - PRESS FIRMLY

**PART OF THE MEDICAL RECORD**

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Vancomycin Physicians Order_NURSING_MEDICAL AFFAIRS