Antibiotics must be ordered on this sheet and include an indication for use. For a renewed or discontinued order, complete first and last sections only.

Diagnosis

Primary Preexisting Condition

BUN Level

Creatinine Level

Allergies:
- A: None Known
- B: Penicillins
- C: Cephalosporins
- D: Other Beta Lactams
- E: Aminoglycosides
- F: Erythromycin, Clindamycin, Lincomycin
- G: Vancomycin
- H: Chloramphenicol
- J: Sulfonamides
- K: Trimethoprim
- L: Nitrofurans, Methenamines
- M: Tetracyclines
- N: Pritamip
- P: Quinolones
- Q: Other

PROPHYLAXIS

Note: Automatic Stop Order if after 24 hours unless reordered.

1. Non-surgical Procedure
2. Biliary Tract
3. Vascular
4. Neurosurgical
5. Obstetrics, Gynecology
6. General Surgery
7. Cardiac
8. Orthopedic
9. Head and Neck
10. Trauma, Burns
11. Gastrointestinal
12. Thoracic
13. Urologic
14. Eyes, Ears, Nose, Throat
15. Other

Operation / Indication:

EMPIRIC

(Diagnosis or Pathogen Not Confirmed) Note: Automatic Stop Order if after 7 days unless reordered.

Infection acquired from:
- C: Community
- N: Nosocomial

Gram Stain(s) Ordered
- A: None
- B: Wound
- C: Blood
- D: Sputum
- E: Urine

Culture(s) Ordered
- A: None
- B: Wound
- C: Blood
- D: Sputum
- E: Urine

THERAPEUTIC

(Documented Infection or Known Pathogens) Note: Automatic Stop Order if after 7 days unless reordered.

Infection acquired from:
- C: Community
- N: Nosocomial

Pathogen(s):

Site of Infection:

ANTIBIOTIC ORDER

DATE ORDERED

TIME ORDERED

□ AM □ PM

N = New Order
R = Renewed Order
C = Changed Order
D = Discontinued Order

Antibiotic

Dose

Route

Frequency

Duration (Days)

Total Doses

FIRST

MI

LAST

BEBEER

SIGNATURE

PHYSICIAN NO.

(PLEASE PRINT)

PHYSICIAN NAME

NURSE NAME

DATE

TIME

ORAL AND PARENTERAL

ANTIBIOTIC ORDER

SHEET