PATIENT INFORMATION

Name _____ (First / MI / Last)

M ☐ Male F ☐ Female Age _____ Weight _____ kg

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.

CLINICAL INFORMATION

Diagnosis _____ CODE NO.

Primary Preexisting Condition _____ CODE NO.

BUN Level _____ Pending ☐ Not Ordered ☐

Creatinine Level _____ Pending ☐ Not Ordered ☐

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 ☐ Rifampin
P ☐ Quinolones
Q ☐ Other _____

ANTIBIOTIC USE

☐ **PROPHYLAXIS** *Note: Automatic Stop Order after 24 hours unless reordered.*

A ☐ Nonsurgical Procedure
B ☐ General Surgery
C ☐ Gastrointestinal
D ☐ Biliary Tract
E ☐ Cardiac
F ☐ Thoracic
G ☐ Vascular
H ☐ Orthopedic
J ☐ Urologic
K ☐ Neurosurgical
L ☐ Head and Neck
M ☐ Eyes, Ears, Nose, Throat
N ☐ Obstetrics, Gynecology
P ☐ Trauma, Burns
Q ☐ Other _____

Operation / Indication: _____ CODE NO.

☐ **EMPIRIC** (Diagnosis or Pathogen Not Confirmed) *Note: Automatic Stop Order 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
F ☐ Cerebrospinal Fluid
G ☐ Other _____

Culture(s) Ordered

A ☐ None
B ☐ Wound
C ☐ Blood
D ☐ Sputum
E ☐ Urine
F ☐ Cerebrospinal Fluid
G ☐ Other _____

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

Site of Infection _____ CODE NO.

Infection acquired from: C ☐ Community N ☐ Nosocomial

Pathogen(s):

A _____ CODE NO.
B _____ CODE NO.
C _____ CODE NO.
D _____ CODE NO.
E _____ CODE NO.

ANTIBIOTIC ORDER

DATE ORDERED▶ TIME ORDERED▶ ☐ AM ☐ PM

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

Date Ordered _____ Time Ordered _____ AM PM

		Antibiotic	Dose	Route	Frequency	Duration (Days)	Total Doses
CODE NO.	1. ☐						
CODE NO.	2. ☐						
CODE NO.	3. ☐						

PHYSICIAN NAME FIRST MI LAST BEEPER (PLEASE PRINT) | SIGNATURE | PHYSICIAN NO.

NURSE SIGNATURE DATE▶ TIME▶

Patient Label

ORAL AND PARENTERAL ANTIBIOTIC ORDER SHEET