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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	Check (✓) Pharmacy Orders	<b>SEVERE / COMPLICATED PNEUMONIA - CLINICAL PATHWAY: DAY 1</b>
			PAGE 1 of 2
			<b>NO PCP, TB, Aspiration</b>
			<b>DATE:</b> _____ <b>TIME:</b> _____
			( Military Time )
			<b>DIAGNOSIS: SEVERE / COMPLICATED PNEUMONIA</b>
			<b>CLASS IV or V</b> (circle one)
			<b>ACTIVITY:</b> BR with BRP. HOB elevated.
			<b>ALLERGIES:</b>
			<b>DIET:</b>
			<b>LABS:</b> _____ if not done in ER:
			1. CBC c diff on DAY 1 (and) DAY 3
			2. UA
			3. BMP
			4. Blood Cultures x 2 (separate sticks)
			5. If productive cough, sputum STAT for gram stain and culture within 4 hours after admission.
			<b>CXR PA &amp; Lateral</b>
			<b>EKG</b>
			<b>VS every 4 hrs X 24 hrs; then every shift</b>
			<b>Document Pulmonary Assessment every shift</b>
			<b>RESPIRATORY THERAPY:</b>
		O2 saturation by oximetry on room air at admission. If less than 95%, do blood gases	
		O2 therapy as indicated after ABG _____ O <sub>2</sub> by _____	
		<b>IV Heparin Lock</b>	
		<b>FLUIDS:</b> _____ @ _____ ml /	
		<b>MEDICATIONS:</b>	
		<b>If Temp &gt; 102 ° F and if Patient is uncomfortable:</b>	
		_____ Motrin 600 mg po every 8 hrs prn	
		_____ Tylenol 650 mg po every 4 - 6 hrs prn	
	<b>FAXED BY/TIME:</b> _____	<b>TIME NOTED:</b> _____	Doctor's Signature _____, MD Date _____
			Nurse's Signature / Title _____

**Military Time > >**

**USE BALL POINT PEN ONLY - PRESS FIRMLY**

**PART OF THE MEDICAL RECORD**

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P A T I E N T I D E N T I F I C A T I O N	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	<b>SEVERE / COMPLICATED PNEUMONIA - CLINICAL PATHWAY: DAY 1</b> <b>(Continued)</b>	NO PCP, TB, Aspiration	PAGE 2 of 2
				<b>DATE:</b>	<b>TIME:</b>
			<b>ANTIBIOTICS - start after cultures - within 4 hrs of admission x 3 days</b> <b>Dosage adjustment required for patients with renal insufficiency.</b>		
			<b>OPTION #1</b> <input type="checkbox"/> Ceftriaxone (Rocephin) 1 gram IV daily <b>AND</b> Azithromycin (Zithromax) 500 mg IV daily.		
			<b>OPTION #2</b> <input type="checkbox"/> Levofloxacin (Levaquin) 750 mg IV daily.		
			<b>OPTION #3</b> <input type="checkbox"/> Piperacillin / Tazobactam (Zosyn) 3.375 gm IV every 6 hours (for confirmed aspiration) <b>AND</b> Azithromycin (Zithromax) 500 mg IV daily.		
			<b>OPTION #4</b> <input type="checkbox"/> Other ... please write orders below <b>clearly</b> .		
			<b>NOTES:</b> 1) Consider Doxycycline for Azithromycin allergic patients. 2) Consider Zosyn 4.5 gms for MDR gram-negative organisms. 3) Antibiotic choices / dosages should be based on patients' clinical assessment.		
			<b>FAXED BY/TIME:</b> _____ <b>TIME NOTED:</b> _____ Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____		

**Military Time >>**

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