PHYSICIANS: PLEASE COMPLETE ALL SECTIONS
PRIOR TO WRITING ANTIBIOTIC ORDERS.

ANTIBIOTIC ORDERS

AUTOMATIC STOP ORDERS

1. SELECT ONE FOR INITIAL WRITTEN ORDER ONLY: IF NO SELECTION IS MADE, ORDER WILL DISCONTINUE IN 72 HOURS.
   - ❑ SURGICAL PROPHYLAXIS
     OPERATION ____________________
   - ❑ EMPIRIC THERAPY - SITE OR PATHOGEN UNKNOWN
     (CULTURES MUST BE ORDERED)
     SUSPECTED SITE ____________________
     SUSPECTED PATHOGEN(S) ____________________
   - ❑ DOCUMENTED INFECTED
     SITE ____________________
     PATHOGEN(S) ____________________
2. ❑ RENEWAL FOR DOCUMENTED INFECTION & LENGTH OF TREATMENT ________

MD Date of Order	Hour of Order	Nurse's Signature	PHYSICIANS: PLEASE COMPLETE ALL SECTIONS PRIOR TO WRITING ANTIBIOTIC ORDERS.
			VANCOMYCIN CAN ONLY BE ORDERED IF ONE OF THE FOLLOWING IS CIRCLED. 1. Methicillin (Nafcillin) resistant gram-positive infection. 2. Penicillin allergy for gram-positive infections, including Group D enterococcus* 3. Ampicillin resistant Group D enterococcus 4. Outpatient Dialysis per Vancomycin protocol 5. Orally, for severe pseudomembranous antibiotic associated colitis where metronidazole has failed 6. Orally for pediatric use (less than age 16) for pseudomembranous antibiotic associated colitis 7. Suspected resistant staphylococcus and streptococcus *PENICILLIN SKIN TESTING MAY BE HELPFUL
			Pediatrics/Neonates: Weight (Kg) ________ Gestational Age (Premature Infants Only) ______
			Postmenstrual Age (Premature Infants Only) ______
			ALLERGIES:
			ALL NECESSARY INFORMATION MUST BE COMPLETED
		I	**ANTIBIOTIC**
			DOSE
			ROUTE
			ANTIBIOTIC INTERVAL
		II	**ANTIBIOTIC**
			DOSE
			ROUTE
			ANTIBIOTIC INTERVAL
		III	**ANTIBIOTIC**
			DOSE
			ROUTE
			ANTIBIOTIC INTERVAL
			Physician's Name: (Print): Physician Signature:

DO NOT WRITE IN THIS AREA

THIS SPACE IS FOR PHARMACY

PLEASE DO NOT RETURN CHARTS WITH NEW ORDERS TO RACK-FLAG CHART
ALL ORDERS MUST BE COUNTER-SIGNED BY A LICENSED PHYSICIAN