Location: _____

Click Here for CMS Sepsis Management Components and Interventions

Diagnostic Criteria:

CMS Sepsis SIRS and Organ Dysfunction Criteria	
Non-Pregnant AND Up to 19 wks and 6 days Pregnant Criteria	**Pregnant 20 wks THROUGH Day 3 Post-Delivery Criteria**
SIRS Criteria	**SIRS Criteria**
* Temp > 38.3 C or < 36.0 C (> 100.9 F or < 96.8 F)	* Temp > 38.0 C or < 36.0 C (> 100.4 F or < 96.8 F)
* HR > 90	* HR > 110
* RR > 20/min	* RR > 24/min
* WBC > 12,000 or 10% bands or < 4,000	* WBC > 15,0000 or 10% bands or < 4,000
Organ Dysfunction	**Organ Dysfunction**
* SBP < 90mmHg or MAP < 65mmHg	* SBP < 85mmHg or MAP < 65mmHg
* SBP decrease of more than 40mmHg	* SBP decrease of more than 40mmHg
* Acute respiratory failure as evidence by a new need for invasive or non-invasive mechanical ventilation (Vent, BiPaP, CPCP, etc.)	* Acute respiratory failure as evidence by a new need for invasive or non-invasive mechanical ventilation (Vent, BiPaP, CPCP, etc.)
* Creatinine > 2.0	* Creatinine > 1.2
* Urine Output < 0.5ml/kg/hr for 2 consecutive hours	* Urine Output < 0.5ml/kg/hr for 2 consecutive hours
* Total Bili > 2.0	* Total Bili > 2.0
* Plt count < 100,000	* Plt count < 100,000
* INR > 1.5 or aPTT > 60sec not related to medication	* INR > 1.5 or aPTT > 60sec not related to medication
* Lactate > 2.0	Lactate > 2.0

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

Treatment:

Treatment:	
Severe Sepsis:	Within 3 hours of presentation or with any clinical suspicion: • Collect initial lactate level • Start broad spectrum antibiotics • Collect blood cultures prior to antibiotics • Administer 30mL/kg crystalloid fluids for hypotension (SBP less than 90 or MAP less than 65), signs and symptoms of acute organ dysfunction, and/or lactic acid greater than 2
	Within 6 hours of presentation: • Repeat lactate if initial lactate greater than or equal to 2
Septic Shock:	Within 3 hours of presentation or with any clinical suspicion: • Administer 30mL/kg crystalloid fluids
	Within 6 hours of presentation: • **IF** hypotension persists Administer vasopressor • **IF** hypotension persist OR initial lactate greater than or equal to 4 Assess volume status and tissue perfusion Focused exam V/S **AND** Cardiopulmonary exam **AND** Capillary refill evaluation **AND** Peripheral pulse evaluation **AND** Skin examination **OR** Any two of the following: CVP measurement Central oxygen measurement Bedside CV U/S Passive leg rise **OR** fluid challenge

IV / Central Line Access - Hemodynamics Monitoring

IV / Central Line Access

- ☐ **Initiate and maintain IV**
  - ☑ **Insert peripheral IV Frequency:** Once **Priority:** Routine
  - ☑ **sodium chloride 0.9 % flush Dose:** 10 mL **Frequency:** every 12 hours scheduled **PRN Reasons:** line care
  - ☑ **sodium chloride 0.9 % flush Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care

Hemodynamic Monitoring

****If patient has IJ or Subclavian Central Venous Line****

- ☐ **Hemodynamic Monitoring - CVP Frequency:** Every hour **Priority:** Routine

Question(s):
Measure: ○ CVP

Nursing

Nursing - HMH, HMSL and HMB

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Vital signs - T/P/R/BP** **Frequency:** Every hour **Frequency Limit:** 3 Hours **Priority:** Routine **Comments:** Monitor every 1 hour for 3 hours, or more frequently as indicated by clinical condition and assessment findings, then re-evaluate frequency of vitals assessment.

☑ **Pulse oximetry** **Frequency:** Daily **Priority:** Routine **Comments:** Place Sp02 monitor (near infrared spectroscopy)
Question(s):
Current FIO2 or Room Air:

☑ **Daily weights** **Frequency:** Daily **Priority:** Routine **Comments:** Notify provider if weight is over 5 pounds from initial dry weight

☑ **Activity: Bed rest initially then progress as tolerated** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Other activity (specify)
Other: Bed rest initially then progress activity as tolerated

☑ **Patient education** **Frequency:** Prior to discharge **Priority:** Routine
Question(s):
Education for: ○ Other (specify)
Specify: Sepsis Education
Patient/Family:

Notify

☐ **Notify Provider/Clinical Response Team:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** -for MAP LESS than 65 or GREATER than 80 -for heart rate LESS than 60 or GREATER than 120 -for urine output LESS than 30 mL/hour -immediately for any acute changes in patient condition (mental status, vital signs)

Initial Management of Suspected Sepsis

Blood Cultures

☐ **Blood culture, aerobic and anaerobic x 2**

☑ **Blood culture, aerobic and anaerobic x 2**

Most recent Blood Culture results from the past 7 days:

@LASTPROCRESULT(LAB462)@

Blood Culture Best Practices (https://formweb.com/files/houstonmethodist/documents/blood-culture-stewardship.pdf)

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:** Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:** Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

Lactic Acid - STAT and repeat 2 times every 2 hours

☐ **Lactic acid level - Now and repeat 2x every 2 hours** **Frequency:** Now and repeat 2x every 2 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** STAT - SPECIMEN MUST BE DELIVERED IMMEDIATELY TO THE LABORATORY. Repeat Lactic Acid in 2 hours. Cancel repeat Lactic Acids if initial or subsequent result is less than or equal to 2.0. Notify physician/APP if Lactic Acid is greater than 2.0.

Click Here for IV Fluids Management Guidance

☐ **IV Fluids**

The target fluid bolus volume can be calculated using the ideal weight as long as the provider indicates that the patient is obese (BMI GREATER than or EQUAL to 30.5). If the provider does not indicate obesity, the actual weight will be used to calculate the target volume.

○ **MEETS criteria for 30 mL/kg** (Required)

○ **Does NOT meet criteria for 30 mL/kg**

◉ **lactated ringers IV bolus and infusion + Vital Signs**

☑ **lactated ringers IV bolus + Vitals Every 15 Minutes x 4 Hours**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **lactated ringers bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately. Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **lactated ringers IV infusion**

☑ **lactated ringer's infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

○ **sodium chloride 0.9% bolus and infusion + Vitals Every 15 Minutes x 4 Hours**

☑ **sodium chloride 0.9% bolus + Vitals Every 15 Minutes x 4 Hours**

☑ **sodium chloride 0.9 % bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately. Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **sodium chloride 0.9% infusion**

☑ **sodium chloride 0.9% infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

○ **Calculate dose using Ideal Body Weight**

◉ **lactated ringers IV bolus and infusion + Vital Signs**

☑ **lactated ringers IV bolus + Vitals Every 15 Minutes x 4 Hours**

☑ **lactated ringers bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately.
Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **lactated ringers IV infusion**

☑ **lactated ringer's infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

○ **sodium chloride 0.9% bolus and infusion + Vitals Every 15 Minutes x 4 Hours**

☑ **sodium chloride 0.9% bolus + Vitals Every 15 Minutes x 4 Hours**

☑ **sodium chloride 0.9 % bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately. Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **sodium chloride 0.9% infusion**

☑ **sodium chloride 0.9% infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

○ **Does NOT meet criteria for 30 mL/kg**

◉ **lactated ringers IV bolus and infusion + Vital Signs**

☑ **lactated ringers IV bolus + Vitals Every 15 Minutes x 4 Hours**

☑ **lactated ringers bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately. Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **lactated ringers IV infusion**

☑ **lactated ringer's infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

○ **sodium chloride 0.9% bolus and infusion + Vitals Every 15 Minutes x 4 Hours**

☑ **sodium chloride 0.9% bolus + Vitals Every 15 Minutes x 4 Hours**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **sodium chloride 0.9 % bolus** **Dose:** 30 mL/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Reassess patient after IV fluid bolus given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of second bolus.
Doses start immediately.
Notify provider immediately upon completion of fluid bolus administration.

☑ **Fluid bolus vital signs - P/R/BP** **Frequency:** Every 15 min **Frequency Limit:** 4 Hours **Priority:** Routine
Primary Ordering Comments:
Monitor vital signs (blood pressure, pulse, respiratory rate) during the IV fluid bolus administration every 15 minutes. Reassess patient and capture one complete sets of vital signs (blood pressure, pulse, respiratory rate) after IV fluid bolus has completed and one more complete set of vital signs every 15 minutes for a total of TWO COMPLETE SETS OF VITAL SIGNS after the IV fluid bolus infusion has completed. If the patient's MAP is not in the target range of 65 to 70 mmHg or if the SBP is LESS than 90 mmHg then notify ordering provider prior to administration of second bolus. Doses start immediately. Notify provider immediately upon completion of IV fluid bolus administration for provider volume status documentation.

☐ **sodium chloride 0.9% infusion**

☑ **sodium chloride 0.9% infusion** **Dose:** 126 mL/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
Reassess patient after 1 L of IV fluid given.
If target not met (MAP 65 to 70 mmHg or SBP GREATER than 90 mmHg), notify ordering provider prior to administration of additional fluids.
Doses start immediately.
Notify provider immediately upon completion of administration of 1 L of fluid.

Antibiotics (Required)
Please Select the appropriate indication(s) for antibiotic use below:

☐ **Chorioamnionitis, Post-partum endometritis, Postabortal infection Antibiotic Treatment**

◉ **Preferred treatment or for penicillin-allergic patients**

☑ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV** **Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus** **Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

☑ **metronidazole IV followed by PO**

☑ **metronidazole (FLAGYL) IV** **Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:

☑ **metroNIDAZOLE (FLAGYL) tablet** **Dose:** 500 mg **Frequency:** every 8 hours
Question(s):
Indication:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **azithromycin (ZITHROMAX) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 24 hours
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection
Product Admin Instructions:
May cause QTc prolongation.

○ **Allergic to azithromycin or metronidazole**

☑ **ampicillin-sulbactam (UNASYN) IV Dose:** 3 g **Route:** intravenous **Frequency:** every 6 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **gentamicin (GARAMYCIN) IV**
Select one based on patient weight

○ **Pt wt < 60 kg: gentamicin (GARAMYCIN) IVPB (maximum 320 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

○ **Pt wt = 60 - 80 kg: gentamicin (GARAMYCIN) IVPB (maximum 400 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

○ **Pt wt > 80 kg: gentamicin (GARAMYCIN) IVPB (maximum 480 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

○ **Severely allergic to cephalosporins**

☑ **gentamicin (GARAMYCIN) IV**
Select one based on patient weight

○ **Pt wt < 60 kg: gentamicin (GARAMYCIN) IVPB (maximum 320 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

○ **Pt wt = 60 - 80 kg: gentamicin (GARAMYCIN) IVPB (maximum 400 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

○ **Pt wt > 80 kg: gentamicin (GARAMYCIN) IVPB (maximum 480 mg) Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection

☑ **clindamycin (CLEOCIN) IV Dose:** 900 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication: Other
Specify: Chorioamnionitis/Endometritis/Postabortal infection
Indication:

☐ **Surgical prophylaxis: Urgent evacuation of uterus (for spontaneous abortion or induced abortion)**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **doxycycline (VIBRAMYCIN) IVPB Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Admin Instructions:
Administer within 1 hour of OR

☑ **metronidazole (FLAGYL) IVPB Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Admin Instructions:
Administer within 1 hour of OR

☐ **Community-Acquired Pneumonia**

◉ **Community Acquired Pneumonia (CAP) Antibiotic Treatment - Medical Floor or ICU Admission**

○ **Medical Floor Admission for Community Acquired Pneumonia - Antibiotic Treatment**

☑ **Beta Lactam/Atypical (choose one option)**

◉ **Beta Lactam/Atypical (NO MDR Risk Factors)**

☑ **Beta Lactam - ampicillin/sulbactam (preferred) or ceftriaxone (penicillin allergy)**

◉ **ampicillin-sulbactam (UNASYN) IV Dose:** 3 g **Route:** intravenous **Frequency:** every 6 hours **Frequency Limit:** 5 Days **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Perinatal Sepsis - CAP Pneumonia
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

○ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

☑ **Atypical - doxycycline (preferred) or azithromycin**

◉ **doxycycline 100 mg IVPB x 1 dose followed by 100 mg capsule twice daily x 2 days**

☑ **doxycycline (VIBRAMYCIN) 100 mg in sodium chloride 0.9% 100 mL IVPB Dose:** 100 mg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **doxycycline (VIBRAMYCIN) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Occurrences
Question(s):
Indication: ○ Respiratory Tract
Admin Instructions:
Hold tube feeds for 2 hours pre- and 2 hours post-administration.

○ **azithromycin 500 mg IVPB on day 1, followed by 500 mg tablet daily x 2 days**

☑ **azithromycin (ZITHROMAX) Dose:** 500 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 1 Days **Start Date:** S **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Product Admin Instructions:
May cause QTc prolongation.

☑ **azithromycin (ZITHROMAX) tablet Dose:** 500 mg **Route:** oral **Frequency:** daily **Frequency Limit:** 2 Days
Question(s):
Indication: ○ Respiratory Tract
Product Admin Instructions:
May cause QTc prolongation.

○ **Beta Lactam/Atypical (Pseudomonas or MDR Risk Factors)**

○ **Cefepime IV and Atypical - doxycycline (preferred) or azithromycin**

☑ **ceFEPime (MAXIPIME) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☑ **Atypical - doxycycline (preferred) or azithromycin**

◉ **doxycycline 100 mg IVPB x 1 dose followed by 100 mg capsule twice daily x 2 days**

○ **azithromycin 500 mg IVPB on day 1, followed by 500 mg tablet daily x 2 days**

○ **(Severe Penicillin Allergy) Meropenem IV and Atypical - doxycycline (preferred) or azithromycin**

☑ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☑ **Atypical - doxycycline (preferred) or azithromycin**

◉ **doxycycline 100 mg IVPB x 1 dose followed by 100 mg capsule twice daily x 2 days**

○ **azithromycin 500 mg IVPB on day 1, followed by 500 mg tablet daily x 2 days**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **MRSA Risk Factors**

○ **Vancomycin IV, Consult, and MRSA PCR**

☑ **vancomycin (VANCOCIN) IVPB Dose:** 25 mg/kg **Route:** intravenous **Frequency:** once
Frequency Limit: 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication: ○ Respiratory Tract
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

○ **(Vancomycin Allergy) Linezolid IV and MRSA PCR**

☑ **linezolid in dextrose 5% (ZYVOX) 600 mg/300 mL IVPB Dose:** 600 mg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

○ **ICU Admission for Community Acquired Pneumonia - Antibiotic Treatment**

☑ **Beta Lactam/Atypical (choose one option)**

◉ **Beta Lactam/Atypical (NO MDR Risk Factors)**

☑ **Beta Lactam - ampicillin/sulbactam (preferred) or ceftriaxone (penicillin allergy)**

◉ **ampicillin-sulbactam (UNASYN) IV Dose:** 3 g **Route:** intravenous
Frequency: every 6 hours **Frequency Limit:** 5 Days **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: Perinatal Sepsis - CAP Pneumonia
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

○ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous
Frequency: every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous
Frequency: every 24 hours **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Atypical - azithromycin (ZITHROMAX) IVPB Dose:** 500 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 3 Days **Start Date:** S **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Product Admin Instructions:
May cause QTc prolongation.

○ **Beta Lactam/Atypical (Pseudomonas or MDR Risk Factors)**

○ **Cefepime IV and Azithromycin IV**

☑ **ceFEPime (MAXIPIME) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☑ **azithromycin (ZITHROMAX) Dose:** 500 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 3 Days **Start Date:** S **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Product Admin Instructions:
May cause QTc prolongation.

○ **(Severe Penicillin Allergy) Meropenem IV and Azithromycin IV**

☑ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☑ **azithromycin (ZITHROMAX) Dose:** 500 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 3 Days **Start Date:** S **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Product Admin Instructions:
May cause QTc prolongation.

☐ **MRSA Risk Factors**

○ **Vancomycin IV, Consult, and MRSA PCR**

☑ **vancomycin (VANCOCIN) IVPB Dose:** 25 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication: ○ Respiratory Tract
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

○ **(Vancomycin Allergy) Linezolid IV and MRSA PCR**

☑ **linezolid in dextrose 5% (ZYVOX) 600 mg/300 mL IVPB Dose:** 600 mg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☐ **Nosocomial Pneumonia OR Community-Acquired Pneumonia with Multi Drug-Resistant Risk**
(e.g. N*ursing home resident, IV antibiotic exposure or hospitalization within previous 90 days, chronic dialysis, immunosuppressed, on home infusion therapy or home wound care)*
Combined use of piperacillin/tazobactam and vancomycin may be associated with an increased incidence of acute kidney injury.

Does your patient have a SEVERE penicillin allergy?

○ **No**

Use meropenem (MERREM) if history of infection with ESBL-producing organism or recent prolonged treatment with piperacillin/tazobactam or cefepime.

○ **ceFEPime 1 g IV + vancomycin 15 mg/kg IV**

☑ **ceFEPime (MAXIPIME) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Pharmacy consult to manage vancomycin** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Adjunct Antibiotics - gentamicin 5 mg/kg IV +/- metroNIDAZOLE 500 mg IV**

☐ **gentamicin (GARAMYCIN) IVPB** **Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source

☐ **metroNIDAZOLE (FLAGYL) IV** **Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

○ **Yes**
(i.e. Type 1 immediate hypersensitivity reaction - anaphylaxis, bronchospasm, angioedema, urticaria)

◉ **aztreonam (AZACTAM) 2 g IV + vancomycin 15 mg/kg IV**

☑ **aztreonam (AZACTAM) IV** **Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Reason for Therapy: Bacterial Infection Suspected
Indication: ○ Sepsis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV** **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Adjunct Antibiotics - gentamicin 5 mg/kg IV +/- metroNIDAZOLE 500 mg IV**

☐ **gentamicin (GARAMYCIN) IVPB** **Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source

☐ **metroNIDAZOLE (FLAGYL) IV** **Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

☐ **Urinary tract infections including pyelonephritis**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

○ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

○ **Cephalosporin Allergy or History of ESBL producing organisms: meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Frequency Limit:** 7 Days **Priority:** STAT
Question(s):
Indication: ○ Uro/Genital
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **Skin and Soft Tissue Infection - Uncomplicated Cellulitis**

◉ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Skin and Soft Tissue Infection - Complicated (necrotizing fasciitis, gangrene, diabetic foot)**

Does your patient have a SEVERE penicillin allergy?

○ **No**

◉ **piperacillin-tazobactam (ZOSYN) IV + vancomycin 15 mg/kg IV**

☑ **piperacillin-tazobactam (ZOSYN) 3.375 g IV**

☑ **piperacillin-tazobactam (ZOSYN) 3.375 g IV Once Dose:** 3.375 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT **Minimum Infusion Duration:** 0.500 Hours
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **piperacillin-tazobactam (ZOSYN) 3.375 g IV every 8 hours** **Dose:** 3.375 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT **Minimum Infusion Duration:** 4.000 Hours
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV** **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Optional Adjunct: clindamycin (CLEOCIN) 900 mg IV** **Dose:** 900 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication:
Admin Instructions:
Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibioticfirst. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

○ **Yes**

◉ **aztreonam (AZACTAM) 2 g IV + vancomycin 15 mg/kg IV + metroNIDAZOLE (FLAGYL) 500 mg IV**

☑ **aztreonam (AZACTAM) IV** **Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Reason for Therapy: Bacterial Infection Suspected
Indication: ○ Sepsis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Priority:** STAT
Question(s):
Reason for Therapy: Bacterial Infection Suspected
Indication: Sepsis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:

☐ **Sepsis of Unknown Source or IV Catheter-Related Infection**

Does your patient have a SEVERE penicillin allergy?

○ **No**

◉ **ceFEPime 1 g IV + vancomycin 15 mg/kg IV**

☑ **ceFEPime (MAXIPIME) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

○ **Yes**
(i.e. Type 1 immediate hypersensitivity reaction - anaphylaxis, bronchospasm, angioedema, urticaria)

◉ **aztreonam (AZACTAM) 2 g IV + vancomycin 15 mg/kg IV**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Reason for Therapy: Bacterial Infection Suspected
Indication: ○ Sepsis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Intra-Abdominal Infections**

Use meropenem if history of infection with ESBL-producing organism or recent prolonged treatment with zosyn or cefepime.
Sources: Complicated Intra-abdominal Infection Guidelines. Clinical Infectious Diseases 2010; 50:133–64. ANTIBIOTIC SUSCEPTIBILITY OF COMMON ORGANISMS – 2016. Houston Methodist Hospital/Department of Laboratory Medicine/Microbiology Section

Does your patient have a SEVERE penicillin allergy?

○ **No**

☑ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

☑ **metronidazole (FLAGYL) Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 5 Days **Priority:** STAT
Question(s):
Indication: ○ Intra-Abdominal
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

○ **Yes**

◉ **aztreonam (AZACTAM) 2 g IV + metroNIDAZOLE (FLAGYL) 500 mg IV**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

☐ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Bacterial Meningitis - Community-Acquired and ImmunoCOMPETENT**

Does your patient have a SEVERE penicillin allergy?

○ **No**

Dexamethasone is recommended for treatment of proven or suspected pneumococcal meningitis due to S. pneumoniae

○ **cefTRIAXone (ROCEPHIN) 2 g IV + vancomycin 15 mg/kg IV - For Patients LESS than 50 years old**

☑ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours
Minimum Infusion Duration: 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **OPTIONAL Additional Therapies - dexamethasone (DECADRON) IV Dose:** 0.15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Administer 15-20 minutes before 1st dose of antibiotics.

○ **cefTRIAXone (ROCEPHIN) 2 g IV + vancomycin 15 mg/kg IV + ampicillin 2 g IV - For Patients GREATER than 50 years old**

☑ **cefTRIAxone (ROCEPHIN) IV**

☑ **cefTRIAxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication: ○ Other
Specify: OB Source Sepsis
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☑ **sodium chloride 0.9 % bolus Dose:** 62.5 mL **Route:** intravenous **Frequency:** every 24 hours
Minimum Infusion Duration: 30.000 Minutes
Admin Instructions:
If lactated ringer's (LR) is currently infusing - piggyback the NS IV bag into the LR, flush, start the cefTRIAxone (ROCEPHIN) IV with the NS infusing, then flush again before returning to the LR.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☑ **ampicillin IV Dose:** 2 g **Route:** intravenous **Frequency:** every 4 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **OPTIONAL Additional Therapies - dexamethasone (DECADRON) IV Dose:** 0.15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Administer 15-20 minutes before 1st dose of antibiotics.

○ **Yes**

Dexamethasone is recommended for treatment of proven or suspected pneumococcal meningitis due to S. pneumoniae

◉ **aztreonam (AZACTAM) 2 g IV + vancomycin 15 mg/kg IV**

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 12 hours **Priority:** STAT
Question(s):
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
LOADING DOSE

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **OPTIONAL Additional Therapies - dexamethasone (DECADRON) IV Dose:** 0.15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Administer 15-20 minutes before 1st dose of antibiotics.

Additional Management of Sepsis

☐ **Colloid / Albumin (for patients not responding to initial fluid resuscitation with crystalloids)**

☐ **albumin human 5 % infusion Dose:** 25 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication:
Admin Instructions:
Administer 500 mL intravenous once for patients not responding to initial fluid resuscitation with crystalloids.

☐ **Vasopressor Therapy (if unresponsive to initial fluid bolus)**

**** if unresponsive to initial fluid bolus ****

○ **norEPInephrine (LEVOPHED) infusion Frequency:** titrated **Priority:** STAT

○ **epINEPHrine infusion Frequency:** titrated **Priority:** STAT

☐ **Inotropic Therapy**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **DOButamine (DOBUTREX) infusion** **Dose:** 0.5 - 20 mcg/kg/min **Route:** intravenous **Frequency:** titrated **Priority:** STAT
Admin Instructions:
Titrate by 2 mcg/kg/min every 10 minutes for mean arterial pressure 65-70 mmHg. Call MD if mean arterial pressure is LESS than 65 mmHg and rate is 10 mcg/kg/min.

☐ **Steroids**

****Per 2012 guidelines, steroid therapy is only recommended in the case of hypotension which is refractory to both fluids and vasopressor therapy. Stress dose steroids should also be considered for patients with a history of recent and/or chronic steroid use****

☐ **hydrocortisone sodium succinate (Solu-CORTEF) injection** **Dose:** 50 mg **Route:** intravenous **Frequency:** every 6 hours **Priority:** STAT
Admin Instructions:
For patients with shock refractory to fluids and vasopressors.

Labs

Laboratory - STAT

☐ **Arterial blood gas** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Venous blood gas** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

☐ **Basic metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with differential** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **NT-proBNP** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Fibrinogen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Ionized calcium** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Deliver specimen immediately to the Core Laboratory.

☐ **Lactic acid level - ONE TIME ORDER ONLY** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Process Instructions:
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☐ **Magnesium** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Phosphorus** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Type and screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

Laboratory - Repeat

- ☐ **Basic metabolic panel** **Frequency:** Every 6 hours **Frequency Limit:** 2 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- ☐ **Blood gas, venous** **Frequency:** Every 6 hours **Frequency Limit:** 2 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- ☐ **CBC with differential** **Frequency:** Every 6 hours **Frequency Limit:** 2 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Laboratory - Additional Microbiology Screens

- ☐ **Aerobic culture** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Anaerobic culture** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
- ☐ **Gastrointestinal pathogens panel WITHOUT C diff**
  - ☑ **Gastrointestinal pathogens panel WITHOUT C diff by nucleic acid amplification** **Frequency:** Once **Priority:** Routine **Specimen Type:** Stool
    Primary Ordering Comments:
    Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.
  - ☑ **Discontinue GI panel order if not collected in 3 days** **Frequency:** Until discontinued **Priority:** Routine **Comments:** This order only exists to discontinue a GI panel order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.
    Primary Ordering Comments:
    This order only exists to discontinue a GI panel order if it has not been collected in 3 days.

    There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.
- ☐ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)**
  - ☑ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)** **Frequency:** Once **Priority:** Routine **Specimen Type:** Stool
    Question(s):
    Reason to order:
    Risk factors:
    Primary Ordering Comments:
    Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.
  - ☑ **Discontinue C diff order if not collected in 3 days** **Frequency:** Until discontinued **Priority:** Routine **Comments:** This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.
    Primary Ordering Comments:
    This order only exists to discontinue a C diff order if it has not been collected in 3 days.

    There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.
- ☐ **Respiratory culture, quantitative** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Mini bronchial alveolar lavage
- ☐ **Respiratory pathogen panel with COVID-19 RT-PCR** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Nasopharyngeal
- ☐ **Sputum culture** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Sputum
- ☐ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
  Question(s):
  Specimen Source: Urine
  Specimen Site:
  Primary Ordering Comments:
  Specimen must be received in the laboratory within 2 hours of collection.

Laboratory - Additional Microbiology Screens

- ☐ **Aerobic culture** **Frequency:** Once **Priority:** Routine
- ☐ **Anaerobic culture** **Frequency:** Once **Priority:** Routine

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **Gastrointestinal pathogens panel WITHOUT C diff**

☑ **Gastrointestinal pathogens panel WITHOUT C diff by nucleic acid amplification** **Frequency:** Once **Priority:** Routine **Specimen Type:** Stool
Primary Ordering Comments:
Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☑ **Discontinue GI panel order if not collected in 3 days** **Frequency:** Until discontinued **Priority:** Routine **Comments:** This order only exists to discontinue a GI panel order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.
Primary Ordering Comments:
This order only exists to discontinue a GI panel order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

☐ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)**

☑ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)** **Frequency:** Once **Priority:** Routine **Specimen Type:** Stool
Question(s):
Reason to order:
Risk factors:
Primary Ordering Comments:
Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☑ **Discontinue C diff order if not collected in 3 days** **Frequency:** Until discontinued **Priority:** Routine **Comments:** This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.
Primary Ordering Comments:
This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☐ **Respiratory culture, quantitative** **Frequency:** Once **Priority:** Routine **Specimen Type:** Mini bronchial alveolar lavage

☐ **COVID-19, influenza A&B, and RSV qualitative RT-PCR** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Specimen Source:

☐ **Sputum culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Sputum

☐ **Urinalysis screen with reflex to culture** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

Imaging

Chest X -Ray

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 2 Vw** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Consults

Antibiotics Pharmacy Consult

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **Pharmacy consult to manage dose adjustments for renal function** **Frequency:** Until discontinued **Priority:** Routine
Comments: Pharmacy consult to review orders for renal dosing prior to administration of second dose of antibiotics
Question(s):
Adjust dose for:
Primary Ordering Comments:
Please assess for hemodialysis, peritoneal dialysis, or continuous renal replacement therapy (CRRT) orders in addition to creatine clearance when making dose adjustments.

Consults - HMH Only

☐ **Consult to Clinical Response Team** **Frequency:** Once **Priority:** Routine
Question(s):
Does the patient display signs and symptoms suspicious of infection at this time? ○ Yes
Reason for Consult? ○ Evaluate patient for sepsis and initiation of Sepsis Acute Care Initial Treatment Protocol

☐ **Consult Infectious Diseases** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult? ○ Consult with Infectious Disease to review and/or adjust current antibiotic selection if necessary. Initial treatment should already be initiated.
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

Consults - Not HMH

☐ **Consult Infectious Diseases** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult? ○ Consult with Infectious Disease to review and/or adjust current antibiotic selection if necessary. Initial treatment should already be initiated.
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

Sign:_____ **Printed Name:**_____ **Date/Time:**_____