Columbus Community Hospital

Columbus, Nebraska

DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS (including Medications)

Vancomycin – Outpatient Antibiotic Therapy Orders 2/2024

1. Vancomycin ____________ mg IV every _____________
2. Indication: ____________________________
3. Duration of therapy____________ or end date: _________________

LABS:

CCH monitors vancomycin therapy using area under the curve (AUC). DoseMeRx dosing software is used with a goal **AUC/MIC of 400-600 mg.h/L for all infections**. Vancomycin levels will be drawn as random levels prior to a patient's 3rd scheduled day.

CCH Pharmacists may recalculate vancomycin dose based on levels using AUC/MIC goal of 400-600 mg.h/L

☐ Yes

☐ No

IF you do NOT wish CCH Pharmacists to recalculate the dose, vancomycin levels should be called to _________________________________ (physician name and phone number) or faxed to_____________________

The current dose with be given as long as level falls between 10-20 mg/mL and dose adjustments will be started with the next scheduled dose.

If levels <10 mg/mL, the patient will be asked to return once new orders can be received.

If levels >20 mg/mL, the dose will be held until new orders are received.

4. Vancomycin level
   - ☐ per CCH Pharmacy (every 3rd dose until within range, then weekly)
   - ☐ at ________________________
5. BMP with each vancomycin level
6. ☐ CBC
   ☐ Other:_______________
7. Frequency of labs:_____________
8. Start IV saline lock or access implanted port per facility protocol.
9. Follow facility policy and/or protocol for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing change.
10. If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider.
    Administer emergency medications per CCH Infusion Center Hypersensitivity Orders
    OR per the following order: ____

Provider signature: _________________________________ Date/Time: _____________________

Printed Name: ________________________ Phone: _____________________ Fax: _____________________

1PON