**PHYSICIAN’S ORDER SHEET**

**COMMUNITY ACQUIRED PNEUMONIA (CAP)**  
Adult Inpatient Initial Therapy and Admission Orders

Any order preceded by a box must be checked to enable the order. All other orders will be automatically implemented.

Use this standard order form for empiric therapy for patients with Community Acquired Pneumonia admitted to **non critical care inpatient units**. This form should not be used for patients with the following:
- Neutropenia
- Suspected or documented aspiration pneumonia
- Immunosuppression/HIV
- Healthcare associated pneumonia
- Suspected pseudomonas pneumonia
- Hematologic malignancy

Questions about specific antibiotic recommendations or classification/diagnosis of community acquired pneumonia should be directed to Infectious Disease, beeper #: **2674**.

1. **Admit to:**
   - **Attending:**__________________________  
   - **Resident:**__________________________  
   - **Intern:**__________________________  
   - **Service:**__________________________  
   - **Team**__________________________
   - **Beeper #:**__________________________

   ☐ Admitted to the Night Float Service, in the morning the patient will be cared for by:
   - **Attending:**__________________________
   - **Resident:**__________________________
   - **Intern:**__________________________  
   - **Beeper #:**__________________________

2. **Diagnosis:** **Community Acquired Pneumonia**
   - **Secondary Diagnosis:**

3. **Condition:**
   - ☐ Satisfactory
   - ☐ Fair/Good

4. **Admission Status:**
   - ☐ Outpatient observation status
   - ☐ Inpatient

5. **Allergies & Reactions:**
   - ☐ No known allergies

6. **Vital Signs:**
   - ☐ Every 4 hours including pulse oximetry
   - ☐ Every shift including pulse oximetry
   - ☐ Other:

7. **Weight Assessment/Intake:**
   - ☐ Admission weight
   - ☐ Weigh daily
   - ☐ I/O every shift
   - ☐ I/O every shift x 48 hours then stop

8. **Diet Order:**
   - ☐ Regular
   - ☐ NPO
   - ☐ Ice chips/sips
   - ☐ Clear liquids
   - ☐ Other:

9. **Activity Level:**
   - ☐ Ad Lib
   - ☐ Out of bed to chair
   - ☐ Ambulate _____ times a day
   - ☐ Bed rest
   - ☐ Bed rest with bathroom privileges
   - ☐ Other:

10. **Oxygen Level:**
    - ☐ Room air
    - ☐ Nasal cannula – titrate to sp 02 greater than ______
    - ☐ Other:

11. **IV Fluid Therapy:**
    - ☐ IVF type __________ additive __________
    - Rate ______ mL/hour
    - ☐ Peripheral catheter, flush per routine
    - Stop after ______ mL or ______ hours
    - ☐ Other:

12. **Call House Officer:**
    - ☐ Pulse less than ______ greater than ______
    - ☐ Respiratory rate less than ______ greater than ______
    - ☐ Systolic BP less than ______ greater than ______
    - ☐ Diastolic BP less than ______ greater than ______
    - ☐ Temperature less than ______ greater than ______
    - ☐ Pulse Ox less than 92% or increasing oxygen requirement

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**A generic equivalent may be administered when a drug has been prescribed by brand name unless the order states to the contrary.**

**Original:** To the medical record  
**Yellow Copy:** Pharmacy

**Approved by:**
- P&T: 7-26-2004 (P-222)
- Medical Records: __________________

**Page 1 of 2**
Any order preceded by a box must be checked to enable the order. All other orders will be automatically implemented.

**National guidelines recommend the following tests:**

| 13. Diagnostic Tests: |  
|-----------------------|---|
| ☐ Chest X-ray (PA and Lateral) | ☐ Portable CXR (if patient unable to stand) |
| ☐ Blood cultures x 2 |  
| ☐ Expectorated sputum gram stain and culture | (Goal: within 4 hrs; obtain result promptly, at least before second antibiotic dose, to determine spectrum of coverage needed.)  
| • Check results of sputum gram stain prior to second dose of antibiotics (if previously obtained) |  
| ☐ CBC with differential | ☐ Now | ☐ In AM |
| ☐ Electrolytes, BUN/Cr | ☐ Now | ☐ In AM |
| ☐ LFTs | ☐ Now | ☐ In AM |
| ☐ Urinary Legionella antigen for patients with enigmatic pneumonia, ICU patients, and patients with failure to respond to a Beta-lactam |  
| ☐ Other: |  

**14. Empiric Antibiotic Therapy:**

**Goal:** First dose of antibiotics in less than 4 hours (associated with decreased length of stay and decreased mortality)

**Hospitalized Patients, Non-ICU (The antibiotics listed below do NOT require ID approval when used with this form)**

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Azithromycin 500 mg PO once daily. - AND – Ceftriaxone 1 gram IV every 24 hours *☐ First Doses Now or ☐ next doses at</td>
</tr>
<tr>
<td>☐ Azithromycin 500 mg IV every 24 hours - AND – Ceftriaxone 1 gram IV every 24 hours *☐ First Doses Now or ☐ next dose at</td>
</tr>
<tr>
<td>☐ Moxifloxacin 400 mg PO once daily *☐ First Doses Now or ☐ next dose at</td>
</tr>
<tr>
<td>☐ Moxifloxacin 400 mg IV every 24 hours *☐ First Doses Now or ☐ next dose at</td>
</tr>
</tbody>
</table>

**If Cephalosporin allergy or anaphylaxis to Penicillin:**

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Moxifloxacin 400 mg PO once daily *☐ First Doses Now or ☐ next dose at</td>
</tr>
<tr>
<td>☐ Moxifloxacin 400 mg IV every 24 hours *☐ First Doses Now or ☐ next dose at</td>
</tr>
</tbody>
</table>

**15. Other Medications:**

| ☐ Albuterol 2.5mg nebulizer treatments every 4 hours PRN wheezing or acute bronchospasm. |
| ☐ Nicotine replacement 14 mg transdermal patch apply daily (less than 10 cigarettes/day) |
| ☐ Nicotine replacement 21 mg transdermal patch apply daily (greater than 10 cigarettes/day) |

**16. Smoking Assessment:**

| ☐ Patient is a non-smoker | ☐ Patient is a smoker (current or quit within 1 year) |
| ☐ Smoker cessation advice given to patient | ☐ Smoking cessation counseling referral |

**17. Vaccination:**

Per DHMC policy/protocol, all inpatients will be assessed and, if appropriate, offered and administered the influenza and pneumococcal vaccine prior to discharge. (See separate assessment/order sheet for protocol.)

| Date: | Date: |
| Current influenza vaccination | Current pneumococcal vaccination |

Signature: ___________________________ MD/ARNP/PA Date & Time: ____________

PRINT Name: ___________________________ Pager/Phone#: __________________

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