DARTMOUTH-HITCHCOCK MEDICAL CENTER
One Medical Center Drive
Lebanon, New Hampshire 03756

CRITICAL CARE SEPSIS ORDERS
FAST-TRACK antibiotics

First dose antibiotics in a Critical Care Unit

Addressograph

Any order preceded by a box must be checked to enable the order.

1. Patient must have *sepsis* and meet following crieria:

Must have 2 out of 4 to meet criteria SIRS:

- ☐ Temp ≥38 or < 36.
- ☐ Heart Rate > 90 beats per minute
- ☐ Respiratory Rate > 20 breaths per minute or pCO_2<32 mmHg.
- ☐ WBC > 12 x 10^9 /L or < 4.0 x 10^9 /L with > 10% bands

To have Sepsis patient must have SIRS with a suspected source of infection

Site of infection: ☐ Specific_____ or ☐ Site unknown.

1. Lab Orders: Microbiology (obtain *prior* to administration of antibiotics when possible)

- ☐ **Blood cultures x 2**
- ☐ **Sputum**
- ☐ **Urine**
- ☐ **Other: _____**

3. **Allergies/ Adverse Drug Reactions** (**Note : Medication <u>will not</u> be dispensed without this information)**

☐ **No Known Drug Allergies or Adverse Drug Reactions (ADRs) OR**

Drug:_____ **Reaction:**_____
Drug:_____**Reaction:**_____
Drug:_____**Reaction:**_____

4. **Antibiotics:** Based on current published sensitivities for DHMC, suspected source of infection and <u>treatment recommendations on the back</u> of this protocol, choose from following:

- ☐ Piperacillin/Tazobactam 3.375 gm IVSS x 1 dose
- ☐ Ceftazidime 2 gm IVSS x 1 dose
- ☐ Ciprofloxacin 400 mg IVSS x 1 dose.
- ☐ Ceftriaxine 2 gm IVSS x 1 dose
- ☐ Azithromycin 500 mg IVSS x 1 dose
- ☐ Tobramycin 7 mg/kg x _____kg = _____mg IVSS over 60 min. x 1 dose.
  Do not use extended interval dosing if patient has acute renal failure
- ☐ Tobramycin 2 mg/kg x _____kg = _____mg IVSS over 60 min x 1 dose (renal failure pts).
- ☐ Vancomycin 15 mg/kg x _____kg = _____ mg over 90 – 120 min x 1 dose.
- ☐ Metronidazole 500 mg IV x 1 dose
- ☐ Clindamycin 900 mg IV x 1 dose

☐ **Other antibiotics:** (complete Antibiotic Order Form and send to pharmacy STAT)

***Note**: This order form is for **first dose STAT antibiotic administration ONLY and <u>does not require ID approval</u>** .*
Please consult ID fellow pager #2674 for additional guidance when possible (Before 11:00 PM)

*****For continued scheduled antibiotics complete "Antibiotic Order Form" with ID approval if necessary*****

MD Signature _____ Pager _____

Print Name _____ Date _____ Hour _____

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

Medical Record Approval Date:
P&T Approval Date: / /03 (P-___)
Original to the medical record
Yellow copy to Pharmacy
Pink copy to MAR