CRITICAL CARE SEPSIS ORDERS
FAST-TRACK antibiotics

First dose antibiotics in a Critical Care Unit

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

1. Patient must have sepsis and meet following criteria:

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 pCO₂ < 32 mmHg.
- WBC > 12 x 10⁹/L or < 4.0 x 10⁹/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 will not 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 treatment recommendations on the back 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.
- Ceftriaxone 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 does not require ID approval.
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: ______________________
Original to the medical record
P&T Approval Date: / /03 (P-___)
Yellow copy to Pharmacy
Pink copy to MAR