



PH2C037

STONY BROOK UNIVERSITY MEDICAL CENTER

UNIT

ANTIMICROBIAL PRESCRIPTION FORM

ANTIMICROBIALS MUST BE ORDERED ON THIS SHEET AND INCLUDE AN INDICATION FOR USE. NON-FORMULARY OR RESTRICTED ANTIBIOTICS REQUIRE ID APPROVAL. USE BALL POINT PEN ONLY.

ALLERGIES: PATIENT WEIGHT (KG):

NEUTROPENIA [] ANC < 100/mm3
RENAL DYSFUNCTION [] Yes [] No [] Not known
DOSAGE ADJUSTMENT ONLY [] Proceed to orders

THERAPEUTIC USE: [] EMPIRIC THERAPY, [] DOCUMENTED INFECTION, [] CONTINUOUS PROPHYLAXIS
SUSPECTED SITE(S): [] Abdominal, [] Bacteremia, [] Bone & Joint, [] CNS, [] Genito-urinary, [] Lower Respiratory, [] Upper Respiratory, [] Skin & Soft Tissue, [] Unknown, [] Other:
SUSPECTED PATHOGEN(S): [] Gram + Aerobe, [] Gram - Aerobe, [] Anaerobe, [] Fungus, [] Other:

DATE: TIME: ORDERS:

SIGNATURE: ID#:

PROPHYLACTIC USE: Automatic stop order at 24 hours.

[] Surgical Site Infection Prophylaxis (Specify Procedure)
[] Continuation of prior order for Surgical prophylaxis (Proceed to orders)

Table with 3 columns: PROCEDURE, SUGGESTED REGIMEN, PENICILLIN ALLERGY. Rows include Clean-high risk, Clean contaminated-UGI, and Clean contaminated-GU/lower GI.

[] Other prophylaxis (e.g. endocarditis). Specify:

DATE: TIME: ORDERS:

SIGNATURE: ID#:

ID approval given by (for restricted antibiotics only):