



PT NAME \_\_\_\_\_

MR # \_\_\_\_\_

**Use Black or Blue Ball Point Pen  
All Entries Must Be Dated and Signed**

DATE & TIME	ORDERS	STAFF NOTES
	<p><b>Admit Dx Pneumonia to:</b></p> <p><input type="checkbox"/> 23 hour obs   <input type="checkbox"/> Full Admit   <input type="checkbox"/> ICU   <input type="checkbox"/> Telemetry</p> <p><b>Condition:</b>   <input type="checkbox"/> Stable   <input type="checkbox"/> Fair   <input type="checkbox"/> Guarded   <input type="checkbox"/> Critical</p> <p><b>Adverse Drug Reactions / Allergies</b> _____</p> <p>_____</p> <p><b>Code Status:</b>   <input type="checkbox"/> Full Code   <input type="checkbox"/> DNAR (DNR/DNI)   <input type="checkbox"/> DNR Only</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p><b><u>Pneumonia Core Measure Categories:</u></b></p> <p><input type="checkbox"/> Oxygen via Protocol for Adult Oxygen Therapy</p> <p><input type="checkbox"/> Provide Smoking Cessation advice / counseling</p> <p><input type="checkbox"/> Administer <u>Pneumococcal Immunization</u> per Hospital Policy</p> <p><input type="checkbox"/> Administer <u>Influenza Immunization</u> per Hospital Policy</p> <p><input type="checkbox"/> Blood Cultures times 2 PRIOR to receiving first dose of Antibiotics</p> <p><input type="checkbox"/> CXR: Indication "rule out pneumonia"</p> <p style="padding-left: 20px;"><input type="checkbox"/> Now   <input type="checkbox"/> PA/LAT   <input type="checkbox"/> Portable</p> <p><b><u>Labs:</u></b></p> <p><input type="checkbox"/> CBC with Differential</p> <p><input type="checkbox"/> Complete Metabolic Panel</p> <p><input type="checkbox"/> Sputum for Gram Stain   <input type="checkbox"/> Culture &amp; Sensitivity</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><b><u>Consults:</u></b></p> <p><input type="checkbox"/> Infectious Disease Medicine Consult</p> <p><input type="checkbox"/> Social Work Consult</p> <p><input type="checkbox"/> Pharmacist Consult to assist with vancomycin, gentamicin and/or tobramycin dosing.</p> <p><b><u>Other Orders:</u></b></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><b>Attending/Primary:</b> Dr. _____ Pager # _____</p> <p><b>Resident/Fellow:</b> Dr. _____ Pager # _____</p>



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	<p><b>ANTIBIOTIC PROTOCOL (PN-6)</b> <i>Select one of the following treatment regimens based on the diagnosis checked at the <b>bottom of right column.</b></i></p> <p><b><u>CAP, general medical ward</u></b></p> <p><input type="checkbox"/> Moxifloxacin 400mg IV/PO Daily</p> <p><input type="checkbox"/> Ceftriaxone 1g (2g if over 80kg) IV Daily (PLUS) Doxycycline 100mg PO/IV q12h</p> <p><input type="checkbox"/> Ceftriaxone 1g (2g if over 80kg) IV Daily (PLUS) Azithromycin 500mg PO/IV Daily</p> <p><b><u>CAP, ICU, no pseudomonas risk factors</u></b></p> <p><input type="checkbox"/> Ceftriaxone 1g (2g if over 80kg) IV Daily (PLUS) Azithromycin 500mg PO/IV Daily</p> <p><input type="checkbox"/> Ceftriaxone 1g (2g if over 80kg) IV Daily (PLUS) Moxifloxacin 400mg PO/IV Daily</p> <p><input type="checkbox"/> Penicillin Allergic: Aztreonam 2g IV q8h (PLUS) Moxifloxacin 400mg PO/IV Daily</p> <p><b><u>CAP, ICU, pseudomonal risk factors</u></b> <i>(Choose 1 from each section A &amp; B)</i></p> <p><b><u>SECTION A:</u></b></p> <p><input type="checkbox"/> Cefepime 2g IV q8h</p> <p><input type="checkbox"/> Piperacillin/tazobactam 4.5g IV q6h</p> <p><input type="checkbox"/> Imipenem/cilastatin 500mg IV q6h</p> <p><input type="checkbox"/> Penicillin Allergic: Aztreonam 2g IV q6h</p> <p><b><u>SECTION B:</u></b></p> <p><input type="checkbox"/> Ciprofloxacin 400mg IV q8h</p> <p><input type="checkbox"/> Azithromycin 500mg PO/IV Daily (PLUS) Gentamicin ____ (5-7mg/kg) IV Daily</p> <p><input type="checkbox"/> Azithromycin 500mg PO/IV Daily (PLUS) Tobramycin ____ (5-7mg/kg) IV Daily</p> <p><b><u>Nosocomial, no known risk factors for MDR</u></b></p> <p><input type="checkbox"/> Ceftriaxone 1g (2g if over 80kg) IV Daily</p> <p><input type="checkbox"/> Moxifloxacin 400mg IV/PO Daily</p> <p><input type="checkbox"/> Ampicillin/Sulbactam 1.5g (3g if over 80kg) IV q6h</p> <p><b><u>Nosocomial, known risk factors for MDR</u></b> (regimens including aminoglycoside plus azithromycin are recommended if Legionella is suspected) <i>(Choose 1 from each section A, B, &amp; C)</i></p> <p><b><u>SECTION A:</u></b></p> <p><input type="checkbox"/> Vancomycin ____ (15mg/kg) IV q12h</p> <p><input type="checkbox"/> Linezolid 600mg IV q12h</p> <p><b><u>SECTION B:</u></b></p> <p><input type="checkbox"/> Cefepime 2g IV q8h</p> <p><input type="checkbox"/> Piperacillin/tazobactam 4.5g IV q6h</p> <p><input type="checkbox"/> Imipenem/cilastatin 500mg IV q6h</p> <p><input type="checkbox"/> Penicillin Allergic: Aztreonam 2g IV q6h (PLUS) Clindamycin 900mg IV q8h</p> <p><b><u>SECTION C:</u></b></p> <p><input type="checkbox"/> Gentamicin ____ (5-7mg/kg) IV Daily</p> <p><input type="checkbox"/> Tobramycin ____ (5-7mg/kg) IV Daily</p> <p><input type="checkbox"/> Ciprofloxacin 400mg IV q8h</p> <p>Physician Signature: _____</p> <p>Provider Number: _____</p> <p>Date: _____ Time: _____</p>	<p><b>COMMUNICATION TOOL FOR EMPIRIC THERAPY FOR ADULT PNEUMONIA</b></p> <p><b>** (Medications must be administered within 6 hours of patient arrival to the hospital) (PN-5)</b></p> <p><b><u>Section I – Assessment for MDR risk factors</u></b> <i>If any of the items in Section I are marked, the patient is at risk for Multi-drug Resistant (MDR) Pathogens and should be treated for nosocomial pneumonia with “known MDR risk factors.”</i></p> <p><input type="checkbox"/> Hospitalization for 2 days or more in the preceding 90 days (Discharge date: _____)</p> <p><input type="checkbox"/> Current hospitalization of 5 days or more</p> <p><input type="checkbox"/> Residence in a nursing home or extended care facility</p> <p><input type="checkbox"/> Antimicrobial therapy in preceding 90 days (Name of antimicrobial(s): _____)</p> <p><input type="checkbox"/> Home infusion therapy (including antibiotics)</p> <p><input type="checkbox"/> Chronic dialysis within 30 days</p> <p><input type="checkbox"/> Home wound care</p> <p><input type="checkbox"/> Family member with multi-drug resistant pathogen (Relation: _____; Pathogen: _____)</p> <p><input type="checkbox"/> Immunosuppressive disease and/or therapy</p> <p><input type="checkbox"/> High frequency of antibiotic resistance in the community, long term care/rehabilitation facility or specific hospital unit</p> <p><b><u>Section II – Assessment for Pseudomonal risk factors</u></b> <i>If any of the items in Section II are present, the patient has Pseudomonal Risk Factors.</i></p> <p><input type="checkbox"/> Structural lung disease (e.g., COPD, bronchiectasis, etc.)</p> <p><input type="checkbox"/> Greater than 10mg/day of prednisone or equivalent</p> <p><input type="checkbox"/> Malnutrition</p> <p><b><u>PNEUMONIA DIAGNOSIS</u></b> (select one based on sections I and II above) Community Acquired Pneumonia = (CAP)</p> <p><input type="checkbox"/> CAP, general medical ward*</p> <p><input type="checkbox"/> CAP, ICU, no pseudomonal factors*</p> <p><input type="checkbox"/> CAP, ICU, pseudomonal factors*</p> <p><input type="checkbox"/> Nosocomial, no known risk factors for MDR</p> <p><input type="checkbox"/> Nosocomial, known risk factors for MDR</p> <p><i>*Consider community-associated MRSA in cases of severe necrotizing pneumonia.</i></p> <hr/> <p><i>Treatment regimens including doxycycline or a fluoroquinolone should be avoided in pregnant patients.</i></p> <hr/> <p><b><i>All antibiotics will be initiated IV and changed to PO according to the IV to PO Conversion Policy unless otherwise specified by circling the route of administration.</i></b></p>