HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

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Check box to initiate order

549007 N09/07

VANCOMYCIN ORDER AND RATIONALE

IMPORTANT
Position patient ID plate so it is to the LEFT of the arrow

ALLERGIC: ☐ NO ☐ YES

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's blood components)	NOTED BY WHOM
	If Vancomycin is the antibiotic of choice, please		☐	Vancomycin (ie Vancocin ®) 1 gm IV one dose	
	document the rationale by checking all that apply			infuse over 90 minutes. Start infusion in Pre-op	
				Line area.	
	☐ Beta –Lactam, penicillin or cephalosporin allergy				
	☐ Known prior colonization with MRSA				
	☐ Acute inpatient hospitalization within the past year				
	☐ Long Term care Resident within the past year				
	☐ Increased MRSA rate, either facility-wide or procedure				
	specific				
	☐ Presence of a chronic wound care or on dialysis				
	☐ In-patient stay more than 24 hours prior to surgery				
	☐ Other reason, please provide rationale:				
	_____				
	_____				
	_____				

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PHYSICIAN'S ORDER FORM

6804

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