

(place patient label here)

Patient Name: _____



PROVIDER ORDERS

Order Set Directions:

- > (✓) - Check orders to activate; Orders with pre-checked box will be followed unless lined out.
- > Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made
- > Initial each page and Sign/Date/Time last page

Diagnosis: _____
Allergies with reaction type: _____

**ORDERS FOR SCHEDULED
"RETURN FOR REPEAT ANTIBIOTICS AND/OR CELLULITIS EVALUATION"**

Version 5 05/14/2014

Date: _____ Time: _____

1. Return for repeat antibiotics as follows (circle all that apply)

Medication	Dosage	Dosing Interval
Rocephin	1 gm or 2 gms	Every ____ hours
Cleocin	900 mg or ____mg	Every ____ hours
Invanz	1 gm	Every 24 hours
Vancomycin	_____	Every ____ hours
Other _____	_____	Every ____ hours
Other _____	_____	Every ____ hours

2. Projected stop date of treatment: _____ (includes final date)

3. Have ED Physician recheck patient (circle all that apply):

First visit of each day

On the following date(s): _____, _____, _____, _____

Every visit

*Have the ED Physician check patient on any visit when patient requests to see the physician or if patient or RN perceives worsening of symptoms or signs of infection, (fever, worse pain, swelling, redness/warmth, lymphangitic streaks, or new complaints)

4. Wound care instructions: _____

5. Pain medication orders (to be given routinely prior to whirlpool/ dressing changes, etc.)

Provider Signature: _____ Date: _____ Time: _____