(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

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: _____

ED Sepsis

Version 8 7/24/19

- Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2012
- Surviving Sepsis Campaign: early goal-directed therapy (first 6 hours): central venous pressure 8 to 12 mm Hg, mean arterial pressure at least 65 mm Hg, ScvO2 at least 70% or SvO2 at least 65%, lactate normalization, urine output at least 0.5 mL/kg/hour

Nursing Orders

- ☑ Verify that blood cultures have been obtained before starting antibiotics
- ☑ Vital signs per unit standard
- ☑ Cardiac monitor
- ☑ Pulse oximetry continuous
- ☑ Oxygen Delivery RN/RT to Determine Titrate to maintain Oxygen saturation greater than 90%
- ☑ Measure (NOT STATED) weight in KG
- ☐ Foley Catheter Insert/Maintain
- ☑ If catheter indwelling for >48 hours, notify provider for catheter change order prior to collecting UA
- ☐ Point of Care Capillary Blood Glucose NOW

IV/ Line Insert and/or Maintain

- ☑ Peripheral IV insert/maintain x 2

IV Fluids - Volume Bolus

30 mL/kg bolus (Edit volume and rate) SELECT if not already done:

Sodium Chloride 0.9% IV

- ☐ _____ milliliter 30 mL/kg BOLUS intravenously WIDE OPEN RATE

IV Fluids - Maintenance

Sodium Chloride 0.9% IV

- ☐ 125 milligram/hour continuous intravenous infusion

Medications

Antibacterial Agents

- Administer appropriate empiric antimicrobials within 1 hour of diagnosis

Pneumonia-Community-acquired

FIRST LINE TREATMENT: No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin: SELECT cefTRIAXone and IV or PO azithromycin

cefTRIAXone (ROCEPHIN)

- ☐ 2 gram intravenously once.

azithromycin (ZITHROMAX)

- ☐ 500 milligram intravenously once.

azithromycin 500 mg tablet (ZITHROMAX)

- ☐ 500 milligram orally once.

Cephalosporin Allergy and/or Anaphylaxis to Penicillin or over 65 years old, History of Alcoholism or on Hemodialysis: SELECT IV or PO levofloxacin

levofloxacin (LEVAQUIN)

- ☐ 750 milligram intravenously once.

levofloxacin 750 mg tablet (LEVAQUIN)

- ☐ 750 milligram orally once

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Community Acquired Pneumonia with history of Pseudomonas Respiratory Infection within the past one year ONLY:

FIRST LINE TREATMENT: No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin: SELECT cefepime and IV or PO levofloxacin

cefepime (MAXIPIME)
- ☐ 2 gram intravenously once.

levofloxacin (LEVAQUIN)
- ☐ 750 milligram intravenously once.

levofloxacin 750 mg tablet (LEVAQUIN)
- ☐ 750 milligram orally once.

Cephalosporin Allergy and/or Anaphylaxis to Penicillin: SELECT* gentamicin *and IV or PO levofloxacin

gentamicin
- ☐ 5 milligram/kilogram intravenously once

levofloxacin (LEVAQUIN)
- ☐ 750 milligram intravenously once.

levofloxacin 750 mg tablet (LEVAQUIN)
- ☐ 750 milligram orally once.

Pneumonia- Nosocomial (recent hospitalization or ECF resident)

No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin: SELECT ALL

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

ciprofloxacin
- ☐ 400 milligram intravenously once

cefepime (MAXIPIME)
- ☐ 2000 milligram intravenously once

Cephalosporin Allergy or Anaphylaxis to Penicillin:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

ciprofloxacin
- ☐ 400 milligram intravenously once

aztreonam (AZACTAM)
- ☐ 2 grams intravenously once

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

UTI with Sepsis (not simple cystitis or uncomplicated pyelonephritis)
No Cephalosporin Allergy and/or No Anaphylaxis to Penicillin:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

cefepime (MAXIPIME)
- ☐ 2 gram intravenously once

fluconazole (DIFLUCAN)
- ☐ 400 milligram intravenously once

Cephalosporin Allergy or Anaphylaxis to Penicillin:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

gentamicin
- ☐ 5 milligram/kilogram intravenously once

fluconazole (DIFLUCAN)
- ☐ 400 milligram intravenously once

Severe Intra-abdominal Infection
No Penicillin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

piperacillin-tazobactam (ZOSYN)
- ☐ 4.5 gram intravenously once

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

Penicillin Allergy and No Cephalosporin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams], then consult pharmacy to dose

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

metroNIDAZOLE (FLAGYL)
- ☐ 500 milligram intravenously once

cefepime (MAXIPIME)
- ☐ 2 gram intravenously once

Penicillin Allergy AND Cephalosporin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

metroNIDAZOLE (FLAGYL)
- ☐ 500 milligram intravenously once

aztreonam (AZACTAM)
- ☐ 2 grams intravenously once

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Sepsis, Source Unknown

No Penicillin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams

piperacillin-tazobactam (ZOSYN)
- ☐ 4.5 gram intravenously once

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

Penicillin Allergy and No Cephalosporin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

metroNIDAZOLE (FLAGYL)
- ☐ 500 milligram intravenously once

cefepime (MAXIPIME)
- ☐ 2 gram intravenously once

Penicillin Allergy AND Cephalosporin Allergy:

vancomycin
- ☐ 15 milligram/kilogram intravenously once [Max dose = 2 grams]

micafungin (MYCAMINE)
- ☐ 100 milligram intravenously once

gentamicin
- ☐ 5 milligram/kilogram intravenously once

metroNIDAZOLE (FLAGYL)
- ☐ 500 milligram intravenously once

Vasoactive Agents

norepinephrine bitartrate in NS 4 mg/250 mL IV (LEVOPHED)
- ☐ 1 microgram/minute continuous intravenous infusion: titrate to keep systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg MAX 30 microgram/minute

EPINEPHrine HCl in 0.9 % NaCl 4 mg/250 mL (16 mcg/mL) IV
- ☐ 0.01 microgram/kilogram per minute continuous infusion: titrate to keep systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg MAX 0.15 microgram/kilogram per minute

DOPamine in D5W 400 mg/250 mL (1,600 mcg/mL) IV
- ☐ 5 microgram/kilogram per minute continuous intravenous infusion: titrate to keep SPB greater than or equal to 90mmHg and MAP greater than or equal to 65 mmHg

DOBUTamine (DOBUTREX) [500 milligram/ 250 milliliter D5W]
- ☐ 2.5 microgram/kilogram per minute continuous intravenous infusion: titrate to keep systolic blood pressure greater than 90 mmHg with goal mean arterial pressure greater than or equal to 65 mmHg and Heart Rate less than 140 beats per minute MAX 10 microgram/kilogram per minute

vasopressin [40 unit/100 milliliter NS]
- ☐ 0.03 unit/minute continuous intravenous infusion: titrate to keep SBP greater than 90mmHg and MAP greater than or equal to 65mmHg MAX 0.04 unit/minute

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Laboratory

Select the following if not already done

- Obtain cultures prior to initiating antimicrobial therapy as long as this does not delay antimicrobial administration for greater than 45 minutes
  - ☑ CBC/AUTO DIFF
  - ☑ COMPREHENSIVE METABOLIC PANEL
  - ☑ MAGNESIUM LEVEL, PLASMA
  - ☐ PHOSPHORUS LEVEL, PLASMA
  - ☐ DIC SCREEN
  - ☐ TROPONIN I
  - ☑ PROCALCITONIN
  - ☐ LACTID ACID, PLASMA every 2 hours x 3
  - ☑ UA WITH MICROSCOPY
  - ☑ BLOOD CULTURE Quantity: 2; Additional Instructions to Phlebotomist: From 2 different sites, 5 minutes apart
  - ☑ CULTURE, URINE
  - ☐ CULTURE, SPUTUM AND GRAM ST

  Blood gas study
  - ☐ Arterial

  - ☐ Blood gas, arterial
  - ☐ TYPE AND SCREEN

  IF indicated Select:
  - ☐ CULTURE, WOUND AND GRAM STAIN [RB]

  IF Female of Menstruating Age and No Hysterectomy Select:
  - ☐ PREGNANCY TEST, SERUM

  IF symptoms of hepatic encephalopathy Select:
  - ☐ AMMONIA, PLASMA

Radiology and Diagnostic Tests

ED ECG (ED Provider Only)
- ☐ stat Reason for exam: _____

XR Chest Single , portable,
- ☐ stat Reason for exam: _____

CT

CT Head without Contrast
- ☐ stat Reason for exam: _____

CT Chest with IV Contrast
- ☐ stat Reason for exam: _____

- CT Renal Colic is a CT abd/pelvis without IV or oral contrast:
  - ☐ CT Renal Colic Reason for exam: _____
- CT Abd/Pelvis with IV includes oral contrast unless otherwise specified:
  - ☐ CT Abd/Pelvis with IV Contrast Reason for exam: _____
- CT Abd/Pelvis without IV includes oral contrast unless otherwise specified:
  - ☐ CT Abd/Pelvis without IV Contrast Reason for exam: _____

Provider Signature:_____Date:_____Time:_____