(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 with reaction type:_____

ORDERS FOR SCHEDULED **Version 5 05/14/2014**

"RETURN FOR REPEAT ANTIBIOTICS AND/OR CELLULITIS EVALUATION"

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:_____