



Patient Identification Information

- SISTERS OF CHARITY HOSPITAL • Buffalo, NY SISTERS OF CHARITY HOSPITAL ST JOSEPH Campus • Cheektowaga, NY
- KENMORE MERCY HOSPITAL • Kenmore, NY MERCY HOSPITAL • Buffalo, NY MERCY HOSPITAL Orchard Park division • Orchard Park, NY

Allergies & Sensitivities

- No Known Allergies (Indicates automatic order. MD to draw line through order to discontinue)

Cellulitis/Soft Tissue Infection

page 1 of 2

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

Date:	Time:	PRESCRIBER ORDERS
Level of Care: Admit to: <input type="checkbox"/> Observation <input type="checkbox"/> Ambulatory Surgery (ASU) <input type="checkbox"/> Inpatient Location: <input type="checkbox"/> Med Surg <input type="checkbox"/> Telemetry (<i>Indication</i>) _____ <input type="checkbox"/> Critical Care Unit Precautions: <input type="checkbox"/> Contact Diagnosis: <input type="checkbox"/> Cellulitis <input type="checkbox"/> Other diagnoses: _____ Admitting Physician: _____ Condition: <input type="checkbox"/> Stable <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical Consults: <input type="checkbox"/> Infectious Disease Consult <input type="checkbox"/> Other: _____ <input checked="" type="checkbox"/> Obtain Health Care Proxy <input type="checkbox"/> Old Records to unit <input type="checkbox"/> Vital signs as per unit/floor protocol <input checked="" type="checkbox"/> Notify MD if: BP less than 90 or greater than 170, HR less than 50 or greater than 120, RR greater than 24, SPO2 less than 92%, Temp less than 95°F or greater than 101°F		
1. ACTIVITY: <input type="checkbox"/> Bedrest <input type="checkbox"/> Bedrest / Commode <input type="checkbox"/> Bedrest / Bathroom Privileges <input type="checkbox"/> OOB to chair <input type="checkbox"/> Ambulate		
2. DIET: <input type="checkbox"/> NPO _____ <input type="checkbox"/> Regular _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Nutrition Consult		
3. IV INFUSION: <input type="checkbox"/> Saline trap <input type="checkbox"/> IV _____ at _____ mL/hour		
4. MEDICATIONS: Antibiotic Therapy: Cellulitis/Lymphangitis: <input type="checkbox"/> Cefazolin (Ancef) 1 gm IV q 8 h <input type="checkbox"/> Oxacillin 2 gms IV q 4 h <input type="checkbox"/> Vancomycin 1 gm IV q 12 h [severe penicillin or cephalosporin allergy] Complicated with abscess /diabetic foot infection with ulceration OR history of MRSA: <input type="checkbox"/> Vancomycin 1 gm IV x q 12 h + piperacillin/tazobactam 4.5 gm IV q 6 h <input type="checkbox"/> Vancomycin 1 gm IV x q 12 h + aztreonam 1 gm IV q 8 h + metronidazole 500 mg IV q 8 h [severe penicillin allergy or cephalosporin allergy]		
Prescriber Signature: _____		



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4. MEDICATIONS: (Continued)

- Analgesia: _____
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- Acetaminophen (Tylenol) 650 mg PO every 4 hours as needed for a temperature greater than _____
- Ibuprofen (Motrin) 400 mg PO every 8 hours as needed for a temperature greater than _____
- Other Medications: **See additional order sheet**

5. LAB STUDIES: If not done in the ED

- CBC/differential
- BMP
- CMP
- Wound culture
- Blood culture (peripheral sites)
- Therapeutic drug levels: _____
- Other labs: _____

Other Studies: Cardiology:

- EKG

Diagnostic Imaging:

- X-ray Chest
- Other: _____

6. Venous Thrombo Embolism Precautions: (VTE) (May Select More than One)

- Sequential Compression Device until ambulatory
- Heparin 5,000 units subcutaneously q 8 h
- Heparin 5,000 units subcutaneously q 12 h
- Enoxaparin (Lovenox) 40 mg subcutaneously daily
- No VTE Prophylaxis (REASON) Not a Candidate Contraindicated Other _____

- 7. Referrals:** Social Work/Care Management Other: _____

Prescriber Signature: _____ **Date:** _____ **Time:** _____