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USE BALL POINT PEN – PRESS FIRMLY

CARONDELET HEALTH NETWORK  
HOSPITAL PROVIDED PRE-PRINTED PHYSICIAN'S ORDERS



STAT/NOW  
(Check Box to Left)

**VANCOMYCIN DOSING**

\* LIST ALL ALLERGIES: (Medication, food, latex and/or Contrast Dye) \* Required on Admission Orders

Pharmacy to dose Vancomycin per \_\_\_\_\_ (prescriber)

Indication: \_\_\_\_\_ Desired trough:  10-15 mg/L  15-20 mg/L  Other: \_\_\_\_\_

**Vancomycin Dosing**

1. **Medication:**
- Vancomycin \_\_\_\_\_ mg IVPB now
  - In addition to Vancomycin \_\_\_\_\_ mg IVPB (already ordered/given)
  - Vancomycin \_\_\_\_\_ mg IVPB every \_\_\_\_\_ hours
  - Dose to be given on \_\_\_\_\_ (date) at \_\_\_\_\_ (time), then dose to be given on \_\_\_\_\_ (date) at \_\_\_\_\_ (time), then standard dosing times
  - Vancomycin \_\_\_\_\_ mg IVPB after each dialysis
  - Future Vancomycin dose to be determined; add Placeholder to MAR
  - Continue current Vancomycin dose

2. Level = \_\_\_\_\_  Trough  Random Comments: \_\_\_\_\_

**Labs**

3.  Vancomycin level
- Trough level 30 minutes prior to dose  Date/time: \_\_\_\_\_
  - Random  Date/time: \_\_\_\_\_
  - BUN/SCr (if not already ordered within the last 24 hours)
  - BUN/SCr every \_\_\_\_\_ while on Vancomycin (unless already ordered)

4.  Hold dose on \_\_\_\_\_ (date) \_\_\_\_\_ (time) until level has been evaluated.  
**DO NOT HOLD DOSE UNLESS THIS BOX IS CHECKED**

<b>Physician/Pharmacist Signature (per physician order to dose)</b>	Date Signed:	Time Signed:
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Physician/Pharmacist <b>Printed Name</b> / License # / Telephone #:	PATIENT IDENTIFICATION
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MEC Approval	CSJ - 02/18/16	CSM - 02/18/16	CHC - 02/25/16	
CHN3032		Expires – 02/2019		