

PHYSICIAN'S ORDER

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

- 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

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

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