

# GYN/UROLOGY - PHYSICIAN ORDER - ADULT ANTIBIOTIC FOR SURGICAL PROPHYLAXIS

Date of Procedure _____	Drug Allergies _____
Height _____ Weight _____	

**Review patient allergies prior to prescribing/administering medications. Please select appropriate boxes.**

Procedure	Drug of choice:	* If Penicillin Allergy:
<b>Gynecologic:</b> -Abdominal hysterectomy, Vaginal Or lap assisted hysterectomy	<b>Preop</b> <input type="checkbox"/> Ampicillin/Sulbactam 3 Gm IV	<b>Preop</b> <input type="checkbox"/> Gentamicin 1.5 mg/kg IV <u>AND</u> Clindamycin 600 mg IV
	<input type="checkbox"/> Cefotetan 2 Gm IV	
	<b>Post-Op</b> <input type="checkbox"/> Ampicillin/Sulbactam 3 Gm IV every 6 hours x 2 doses	<input type="checkbox"/> Gentamicin IV Pharmacy to dose <u>AND</u> Clindamycin 600 mg IV every 8 hours x 2 doses
	<input type="checkbox"/> Cefotetan 2 Gm IV every 12 hours x 1 dose	
	<input type="checkbox"/> Metronidazole 500 mg IV every 6 hours x 2 doses <u>AND</u> Ciprofloxacin 400 mg IV every 12 hours x 1 dose	
<b>Genitourinary</b> Pubovaginal Sling	<b>Preop</b> <input type="checkbox"/> Cefotetan 2 Gm IV	<b>Preop</b> <input type="checkbox"/> Ciprofloxacin 400 mg IV
	<input type="checkbox"/> Ampicillin/Sulbactam 3 Gm IV	
	<b>Post-Op</b> <input type="checkbox"/> Cefotetan 2 Gm IV every 12 hours x 1 dose	<b>Post-Op</b> <input type="checkbox"/> Ciprofloxacin 400 mg IV every 12 hours x 1 dose
	<input type="checkbox"/> Ampicillin/Sulbactam 3 Gm IV every 6 hours x 3 doses	

Doses are adjusted according to renal function. Duration of prophylaxis is NOT to exceed 24 hours from surgery close time. **Overwritten orders will not be dispensed by pharmacy since they do not meet evidenced based guidelines unless suspected infection is documented here:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Pager: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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PATIENT LABEL



**MR.ORDER**