NEURO - 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:
Neurological	**Preop** ☐ Cefazolin 1 Gm IV (if wt less than 80 kg) ☐ Cefazolin 2 Gm IV (if wt greater than or equal to 80 kg)	**NOTE: High Risk for MRSA** ☐ Nursing home patient ☐ Dialysis patient ☐ Recent Hospitalization ☐ Recurrent antibiotic treatment ☐ Chronic Wound Care ☐ Known Prior colonization ☐ Other _____
	☐ Nafcillin 1 Gm IV	
	☐ Vancomycin 1 Gm IV for patient at high risk for MRSA (Reason must be specified _____)* see note	
	Post-Op ☐ Cefazolin 1 Gm IV every 8 hours x 2 doses (if wt less than 80 kg) ☐ Cefazolin 2 Gm IV every 8 hours x 2 doses (if wt greater than or equal to 80 kg)	**Preop** ☐ Vancomycin 1 Gm IV
	☐ Nafcillin 1 Gm IV every 6 hours x 3 doses	**Post-Op** ☐ Vancomycin 1 Gm IV every 12 hours x 1 dose
	☐ Vancomycin 1 Gm IV every 12 hours x 1 dose for patient at high risk for MRSA (Reason must be specified _____)* see note	

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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A Ministry of the Sisters of Charity Health System

PATIENT LABEL

MR.ORDER