

**PHYSICIAN ORDERS  
COMMUNITY ACQUIRED PNEUMONIA**

PAGE 1 OF 2  
(ESTIMATED LOS - 5 DAYS)

DIAGNOSIS:		
DRUG ALLERGIES		
DATE / TIME ORDERED	ORDERS AND SIGNATURE	NURSE'S INITIALS
	<b>ADMIT TO PHYSICIAN:</b>	
	<b>Consult:</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Other _____	
	<b>Vital Signs:</b> every _____ hours for _____ hours then every _____ hours	
	<input type="checkbox"/> Pulse Oximetry _____ <input type="checkbox"/> FIO <sub>2</sub> _____	
	<b>Activity:</b> <input type="checkbox"/> Ambulate ad lib <input type="checkbox"/> Ambulate w/ assistance <input type="checkbox"/> Other _____	
	*If no activity specified, ambulate w/ assistance.	
	<b>Diet:</b>	
	<input type="checkbox"/> Aspiration Precaution	
	<b>Tests:</b> <input type="checkbox"/> CBC with diff <input type="checkbox"/> PT/PTT <input type="checkbox"/> Basic Metabolic Profile	
	<input type="checkbox"/> Blood C&S x 2 one half hour apart prior to Antibiotic and within four hours of admission	
	<input type="checkbox"/> U/A and Urine C/S	
	<input type="checkbox"/> Sputum Gm Stain and C&S (preferably prior to antibiotic administration)	
	<input type="checkbox"/> Chest X-Ray (if not done in ED) PA and Lateral	
	<input type="checkbox"/> EKG	
	<input type="checkbox"/> Other _____	
	<b>Treatments:</b> <input type="checkbox"/> Antibiotic (See Medication Sheet) _____	
	_____	
	<input type="checkbox"/> IV Fluid _____ <input type="checkbox"/> Medlock _____	
	_____	
	<input type="checkbox"/> I&O <input type="checkbox"/> Oxygen	
	<input type="checkbox"/> Respiratory Treatments <b>EITHER</b> <input type="checkbox"/> Albuterol (Proventil®) 0.083% 3mL via Nebulizer every _____ hour(s)	
	<b>OR</b> <input type="checkbox"/> Ipratropium Bromide (Atrovent®) 0.02% 2.5mL via Nebulizer every 8 hours	
	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> old chart to floor	
	<b>DVT Prophylaxis:</b>	
	<input type="checkbox"/> Pneumatic Compression Stockings	
	<input type="checkbox"/> Consider anticoagulation therapy (order on page 2)	
	<input type="checkbox"/> Influenza Vaccine Screening & Evaluation as per protocol	
	<input type="checkbox"/> Pneumococcal Vaccine Screening & Evaluation as per protocol	
	<input type="checkbox"/> Smoking Cessation Education <input type="checkbox"/> N/A	
	<input type="checkbox"/> Other _____	
	<b>(SEE PAGE 2 FOR MEDICATIONS - CONTINUE ON BACK PAGE)</b>	
	<b>PHYSICIAN SIGNATURE:</b> _____ <b>I.D. #</b> _____	

FORM # 22504 CF 1.2 Rev. 10/27/2006 HYGRADE BUSINESS GROUP

APPROVED THERAPEUTICALLY EQUIVALENT PRODUCTS WILL BE USED UNLESS OTHERWISE INDICATED

*Please write legibly—Remember ID # after signature*

MERCY MEDICAL CENTER

1000 North Village Avenue / Rockville Centre, NY 11570

**PHYSICIAN ORDERS  
COMMUNITY ACQUIRED PNEUMONIA**

PAGE 2 OF 2  
(ESTIMATED LOS - 5 DAYS)

DIAGNOSIS:

DRUG ALLERGIES

DATE / TIME ORDERED	ORDERS AND SIGNATURE	NURSE'S INITIALS
	<p><b>Medications:</b> Antibiotics initiated <b>within 4 hrs. of arrival. (Choose one Protocol)</b></p> <p><b>Protocol A</b>    <input type="checkbox"/> Levofloxacin (Levaquin®) _____ mg    <input type="checkbox"/> IV <b>OR</b> <input type="checkbox"/> Orally daily (For mild to severe pneumonia)</p> <p><b>Protocol B</b>    <input type="checkbox"/> Ceftriaxone (Rocephin®) 1gm IVPB daily <b>Plus</b> (For moderate to    <input type="checkbox"/> Azithromycin (Zithromax®) 500mg IV daily <b>OR</b> severe pneumonia)    <input type="checkbox"/> Azithromycin (Zithromax®) 500mg orally stat then 500mg orally daily</p> <p><b>Protocol C</b>    <input type="checkbox"/> Ceftriaxone (Rocephin®) 1gm IVPB daily (For moderate to <b>AND</b> <input type="checkbox"/> Levofloxacin (Levaquin®) _____ mg IV daily severe pneumonia) <b>OR</b>    <input type="checkbox"/> Levofloxacin (Levaquin®) _____ mg orally daily</p> <p><b>* Consider switching antibiotic to oral on Day three if GI system is functional and co-morbid conditions are stable.</b></p>	
	<p style="text-align: center;"><b>Indicators of severe pneumonia</b></p> <p>Confusion Respiration rate greater than 30 breaths per minute Blood urea nitrogen greater than 19 mg/dL Creatinine greater than 2mg/dL, urinary output less than 20 mL/h Blood pressure greater than or equal to 90/60mm Hg PaO<sub>2</sub> FiO<sub>2</sub> less than 250 Multilobar disease Age greater than 65 years White blood cell count greater than 20 x 10<sup>3</sup>/uL Leukopenia (less than 4 x 10<sup>3</sup>/uL) FiO<sub>2</sub> fraction of Inspired oxygen</p>	
	<p><b>PHYSICIAN SIGNATURE:</b> _____ <b>I.D. #</b> _____</p>	

APPROVED THERAPEUTICALLY EQUIVALENT PRODUCTS WILL BE USED UNLESS OTHERWISE INDICATED

*Please write legibly—Remember ID # after signature*