

MERIDIAN HEALTH JSUMC•OMC•RMC•BCH•SOMC  
**PRE-OPERATIVE (INPATIENT/OUTPATIENT)**  
**PROPHYLACTIC SURGICAL ANTIBIOTIC ORDER FORM**  
**HYSTERECTOMY SURGERY**  
 70395-081CX (1-14)S



\*PO1607\*

Weight: \_\_\_\_\_

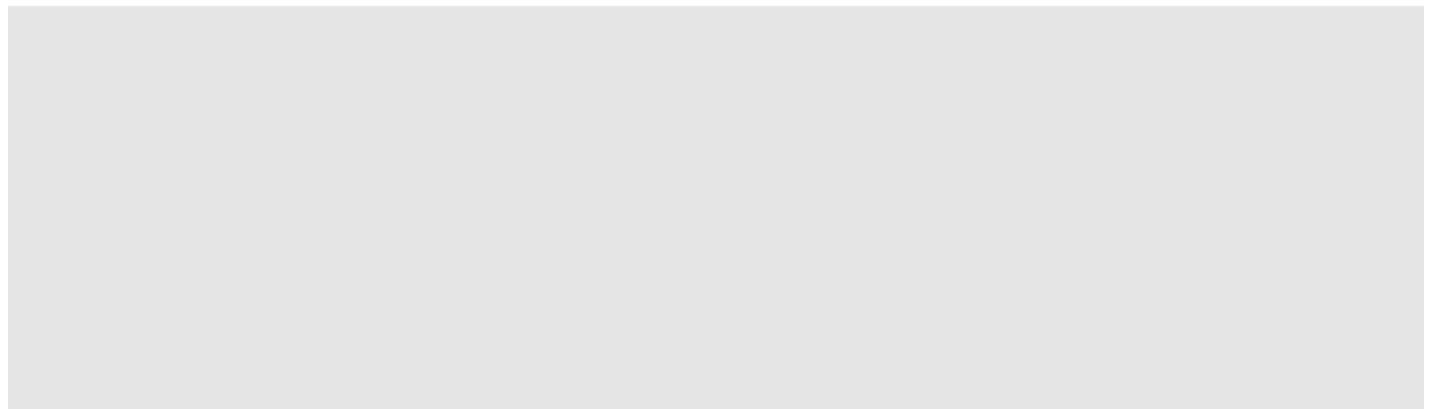
Antibiotic Allergies: \_\_\_\_\_ (specify reaction below)

Reaction:  Rash  Hives  Anaphylaxis  GI/CNS Symptoms  Other

***Antibiotic to be administered within 1 hour prior to surgical incision.***

If infection is discovered at time of surgery, please order antibiotics on regular order form post operatively.

CLEAN-CONTAMINATED SURGERY	
<b>Hysterectomy</b>	<input type="checkbox"/> If < 80 kg: Cefazolin 1g/SWFI 10mL IV x 1 dose
	<input type="checkbox"/> If 80-120 kg: Cefazolin 2g/SWFI 20mL IV x 1 dose
	<input type="checkbox"/> If > 120 kg: Cefazolin 3g/SWFI 30mL IV x 1 dose
	<input type="checkbox"/> Cefotetan 1g/50mL NS IV x 1 dose
	<input type="checkbox"/> Cefoxitin 2g/100mL NS IV x 1 dose
	<input type="checkbox"/> If beta-lactam allergy: Clindamycin 900mg/50mL D5W IV x 1 dose <b>AND</b> Gentamicin (1.5mg/kg) _____mg IV x 1 dose
<input type="checkbox"/> If beta-lactam allergy: Metronidazole 500mg/100mL NS IV x 1 dose <b>AND</b> Ciprofloxacin 400mg/200mL D5W IV x 1 dose	



Telephone Order with Read Back Initials: \_\_\_\_\_

Verbal Order with Repeat Back Initials: \_\_\_\_\_

NURSE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ AM/PM

PRESCRIBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ AM/PM