MERIDIAN HEALTH JSUMC•OMC•RMC•BCH•SOMC

PRE-OPERATIVE (INPATIENT/OUTPATIENT)
PROPHYLACTIC SURGICAL ANTIBIOTIC ORDER FORM
ORTHOPEDIC AND PODIATRIC SURGERY

70395-083CX (1-14)S

PO1609

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.
Vancomycin to be administered within 2 hours prior to surgical incision.

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

CLEAN SURGERY	
Implantable Devices (Shunts, Screws, Pins, Rods, Prosthetic Joints) Or Podiatry or Orthopedic	☐ If <80 kg: Cefazolin 1g/SWFI 10mL IV x 1 dose ☐ If 80-120 kg: Cefazolin 2g/SWFI 20mL IV x 1 dose ☐ If > 120 kg: Cefazolin 3g/SWFI 30mL IV x 1 dose
	If beta-lactam allergy: ☐ If < 80 kg: Vancomycin ** 1g/200mL iso-osmotic IV x 1 dose ☐ If 80-100 kg: Vancomycin** 1.25g/250mL NS IV x 1 dose ☐ If >100 kg: Vancomycin** 1.5g/250mL NS IV x 1 dose
	☐ If beta-lactam allergy: Clindamycin 900mg/ 50mL D5W IV x 1 dose

****Vancomycin is acceptable with documented justification for its use.**
Acceptable reasons for Vancomycin use listed below.

☐ Beta-lactam (penicillin or cephalosporin) allergy

☐ Known prior colonization with MRSA

☐ Patient high-risk due to acute inpatient hospitalization within the last year

☐ Patient being high-risk due to LTC setting within the last year, prior to admission

☐ Increased MRSA rate, either facility-wide or procedure-specific

☐ Chronic wound care or dialysis

☐ Continuous inpatient stay more than 24 hours prior to the procedure of interest

☐ Patient undergoing valve surgery

☐ Patient transferred from another inpatient hospitalization after 3 day stay

☐ Other reason for Vancomycin use:_____

☐ Telephone Order with Read Back Initials:_____ ☐ Verbal Order with Repeat Back Initials: _____

NURSE SIGNATURE:_____ DATE:_____ TIME:_____AM/PM

PRESCRIBER SIGNATURE:_____ DATE:_____ TIME:_____AM/PM