Sterile Products Order Form								
Patient:	Ward:	Date/Time of First Dose		Schedule/Rate		Order Number:		
Notes:				Transcriber:		Checker:		
Additives:				**Volume:**	**Route:**	**Dosage Form**		
Ampicillin	_____mg	Cefazolin	_____mg	1000ml	IV	Syringe		
Cefotetan	_____mg	Ceftazidime	_____mg	500 ml	IVPB	Bag		
Ceftriaxone	_____mg	Chloramphenicol	_____mg	250 ml	IVP	Bottle		
Chloroquine	_____mg	Clindamycin	_____mg	100ml	IRR			
Erythromycin	_____mg	Gentamicin	_____mg	50 ml	IM			
Levofloxacin	_____mg	Metronidazole	_____mg		SQ	**First Day of Administration**		
Penicillin G	_____mg	Unasyn	_____mg	**Solution:**				
Vancomycin	_____mg			D5W	D5- 1/4NS	01	09	17
Aminophylline	_____mg	Dopamine	_____mg	D5-1/2 NS	D5-1/3 NS	02	10	18
Furosemide	_____mg	Heparin	____units	D5-NS	NS	03	11	19
Hydrocortisone	_____mg	Insulin (Reg)	____units	Notes:		04	12	20
Lidocaine	_____mg	Mannitol	_____mg			05	13	21
Nitroglycerine	_____mg					06	14	22
Potassium Chloride	____mEq	Sodium Chloride	____mEq			07	15	23
Sodium Bicarb.	mEq					08	16	24

Sterile Products Order Form								
Patient:	Ward:	Date/Time of First Dose		Schedule/Rate		Order Number:		
Notes:				Transcriber:		Checker:		
Additives:				**Volume:**	**Route:**	**Dosage Form**		
Ampicillin	_____mg	Cefazolin	_____mg	1000ml	IV	Syringe		
Cefotetan	_____mg	Ceftazidime	_____mg	500 ml	IVPB	Bag		
Ceftriaxone	_____mg	Chloramphenicol	_____mg	250 ml	IVP	Bottle		
Chloroquine	_____mg	Clindamycin	_____mg	100ml	IRR			
Erythromycin	_____mg	Gentamicin	_____mg	50 ml	IM			
Levofloxacin	_____mg	Metronidazole	_____mg		SQ	**First Day of Administration**		
Penicillin G	_____mg	Unasyn	_____mg	**Solution:**				
Vancomycin	_____mg			D5W	D5- 1/4NS	01	09	17
Aminophylline	_____mg	Dopamine	_____mg	D5-1/2 NS	D5-1/3 NS	02	10	18
Furosemide	_____mg	Heparin	____units	D5-NS	NS	03	11	19
Hydrocortisone	_____mg	Insulin (Reg)	____units	Notes:		04	12	20
Lidocaine	_____mg	Mannitol	_____mg			05	13	21
Nitroglycerine	_____mg					06	14	22
Potassium Chloride	____mEq	Sodium Chloride	____mEq			07	15	23
Sodium Bicarb.	mEq					08	16	24

Sterile Products Order Form								
Patient:	Ward:	Date/Time of First Dose		Schedule/Rate		Order Number:		
Notes:				Transcriber:		Checker:		
Additives:				**Volume:**	**Route:**	**Dosage Form**		
Ampicillin	_____mg	Cefazolin	_____mg	1000ml	IV	Syringe		
Cefotetan	_____mg	Ceftazidime	_____mg	500 ml	IVPB	Bag		
Ceftriaxone	_____mg	Chloramphenicol	_____mg	250 ml	IVP	Bottle		
Chloroquine	_____mg	Clindamycin	_____mg	100ml	IRR			
Erythromycin	_____mg	Gentamicin	_____mg	50 ml	IM			
Levofloxacin	_____mg	Metronidazole	_____mg		SQ	**First Day of Administration**		
Penicillin G	_____mg	Unasyn	_____mg	**Solution:**				
Vancomycin	_____mg			D5W	D5- 1/4NS	01	09	17
Aminophylline	_____mg	Dopamine	_____mg	D5-1/2 NS	D5-1/3 NS	02	10	18
Furosemide	_____mg	Heparin	____units	D5-NS	NS	03	11	19
Hydrocortisone	_____mg	Insulin (Reg)	____units	Notes:		04	12	20
Lidocaine	_____mg	Mannitol	_____mg			05	13	21
Nitroglycerine	_____mg					06	14	22
Potassium Chloride	____mEq	Sodium Chloride	____mEq			07	15	23
Sodium Bicarb.	____mEq					08	16	24