Place Your Hospital Name
ORDER SHEET

Orders for Single Agent Antifungal Therapy

for addressograph plate

Ordered		SIGN EACH ENTRY – INCLUDE ID NUMBER	Noted by	Order Completed		Initials
Date	**Time**	*use a ball point pen, press firmly*		**Date**	**Time**	
		00 Patient weight (kg) = _____				
		01 Notes • Please check one of the following indications and corresponding medication.				
		02 ☐ Management of **neutropenic fever** Please choose one of the following**:** ☐ **Antifungal 1** **OR** ☐ **Antifungal 2**				
		03 ☐ Initiation of therapy for the management of possible, probable, or definite **pulmonary aspergillosis infection**. Please choose one of the following: ☐ **Antifungal 1** **OR** ☐ **Antifungal 2**				
		04 ☐ Initiation of therapy for the management of **unspeciated candidemia or disseminated candidiasis** Please choose one of the following: ☐ **Antifungal 1** **OR** ☐ **Antifungal 2**				
		05 ☐ Continuation of therapy for possible, probable, or definite **pulmonary aspergillosis infection** or **disseminated candidiasis infection** in patients who are admitted on daily antifungal therapy. Note: Please reassess patient for need to modify current antifungal therapy. Please choose one of the following: ☐ **Antifungal 1** **OR** ☐ **Antifungal 2**				
		06 ☐ Initiation of therapy for the management of **oral and/or esophageal candidiasis** Please choose one of the following: ☐ **Antifungal 1** **OR** ☐ **Antifungal 2**				
		07 _____ MD, _____ID #_____ Beeper				