MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
DIRECTORATE OF NURSING SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.5A	20 Jun 2014

LOCAL FORM TITLE *(Optional)*
OB/GYN - LDRP GBS PROPHYLAXIS

Date: _____ Time: _____

GBS Prophylaxis:

- ☐ Positive culture this pregnancy,
- ☐ Culture results unknown and risk factors present,
- ☐ Previous infant with invasive GBS disease, GIVE:
  - ☐ Penicillin G POT, 5 million units IVPB (infuse over 30 minutes) as 1st dose, then 3 million units IVPB every 4 hours (infuse over 30 minutes) . Discontinue after delivery.
  - ☐ Ampicillin 2 grams IVPB (infuse over 60 minutes) as 1st dose, then 1 gram IVPB every 4 hours (infuse over 30 minutes 4 hours after 2 gram 1st dose). Discontinue after delivery.

For penicillin allergy:

- ☐ Vancomycin 1 GM IVPB every 12 hours (infuse over 60 minutes). Discontinue after delivery.
- ☐ Clindamycin (Cleocin) 900 mg IVPB every 8 hours (infuse over 90 minutes). Discontinue after delivery.
- ☐ Cefazolin (Ancef) 2 GM IVPB infuse over 30 minutes as 1st dose, then 1 gram IVPB every 8 hours (infuse over 30 minutes 8 hours after 2 GM 1st dose). Discontinue after delivery.

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	