Attachment B: Loeb Criteria Communication and Order Form

Form Approved
OMB No. XXXX-XXX
Exp. Date XX/XX/XXXX

Communication and Order Form

Please use the communication and order form to document all infections.

Please use Section II to document whether a resident has a skin or soft tissue infection, a urinary tract infection, a suspected lower respiratory tract infection, or a fever of unknown origin.

Please fill out as much information as possible, indicating whether the Loeb criteria were met.

Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

Communication and Order Form (v.8)

Clinician:	Facility:
Fax:	Facility Nurse:
Phone:	Phone:
Resident/Rm#:	Date & Time faxed/reported:

I. Vital Signs: Temp.: _________ BP: ______________ Resp. Rate: ________ Heart Rate: _________ O_2 Sat:__________

II. Infections and Fevers- Loeb Criteria for Antibiotic Use (CHECK ALL THAT APPLY)

☐ **Skin or Soft Tissue Infection, check all that apply**
Site:____
☐ New or increasing purulent discharge at site
☐ **OR AT LEAST TWO** of the following: ☐ Fever over 100°F or increase of 2.4°F above baseline temp.;
☐ Redness; ☐ Tenderness; ☐ Warmth;
☐ New/increased swelling
☐ Loeb criteria met

☐ **Suspected Urinary Tract Infection (choose 1 of 2)**
(1) ☐ **For Pts. with a chronic indwelling catheter,** check at least 1:
☐ Fever over 100°F or increase of 2.4°F above baseline
☐ New costovertebral angle tenderness (flank pain)
☐ Rigors (shaking chills)
☐ Delirium (sudden onset of confusion)
(2) ☐ **For Pts. without a chronic indwelling catheter, check all that apply:**
☐ Acute dysuria **OR**
☐ Fever over 100°F or increase in 2.4°F above baseline temp.
AND AT LEAST ONE new or worsening:
☐ Urgency; ☐ Frequency; ☐ Suprapubic pain ;
☐ Gross hematuria ; ☐ Costovertebral angle tenderness; or ☐ Urinary incontinence
☐ Loeb criteria met

☐ **Fever of Unknown Origin, check all that apply**
☐ Fever over 100°F or increase in 2.4°F above baseline patient needs to have **AT LEAST ONE** of the following:
☐ Delirium ☐ Rigors (shaking chills)
☐ Loeb criteria met

☐ **Suspected Lower Respiratory Infection (choose 1 of 4)**
☐ **For patients with a fever:**
(1) ☐ If fever is 102°F or greater Pt. must also have **AT LEAST ONE** of the following:
☐ Resp. rate > 25 breaths/min. ☐ Productive cough
(2) ☐ If fever is between 100 - 102°F Pt. **MUST** have a ☐ Cough **AND AT LEAST ONE** of the following:
☐ Pulse > 100 ☐ Delirium
☐ Rigors ☐ Resp. rate >25 breaths/min
☐ **For patients without a fever:**
(3) ☐ If Pt. does not have COPD, Pt. must have
☐ New or increased cough with purulent sputum production **AND AT LEAST ONE** of the following:
☐ Resp. rate > 25 breaths/min. ☐ Delirium
(4) ☐ If Pt. has **COPD** Pt. must have
☐ New or increased cough with purulent sputum production
☐ Loeb criteria met

III. Additional information

____
____
____
____

____
Nurse Signature Date/Time

FAMILY/POA NOTIFIED: Date & Time reported: ____________________ Name: ____

Treatment # 1:______________	Treatment #2: ______________	☐ Lab Tests: ______________
Dosage: ______________	Dosage: ______________	______________
Frequency:______________	Frequency:______________	☐ X-ray ordered
Other: ______________	Other:______________	☐ **No changes at this time**
Comments/Other Instructions:		
Clinician Signature	Date/Time	☐ Telephone order received