

ANTIBIOTIC AUDIT REPORT

PATIENT INFORMATION

Name: _____

Admit Date _____

Record No: _____

Unit: _____

DOB: _____

Service: _____

Gender: _____

Admit Source: _____

Age: _____

Allergies: _____

Weight (lb): _____

CLINICAL INFORMATION

Admitting Diagnosis: _____

Prior Medical History: _____

Recent Antibiotics: Y/N _____

Immunocompromised: Y/N _____ Septic: Y/N

Suspected Site of Infection: Lungs Abdomen Urine/Bladder Bloodstream

Other: _____

TMax _____ WBC _____ CrCl _____

Culture Results: Date: _____ Site: _____ Pathogen: _____

ANTIBIOTIC INFORMATION

Date: _____ Agent: _____ Dose: _____ Route: _____ Prescriber: _____

AUDIT SUMMARY

Evaluation of Antibiotic Use: Appropriate Not Appropriate

Rationale: _____

Feedback: _____