ANTIBIOTIC STEWARDSHIP LOG

Patient ID Label

Abx Ordering MD(s): _____/_____/_____

Suspected Infection Source/Cause: _____

Please also USE: Culture Log and/or MDRO Log to document culture findings

INITIAL Antibiotics - Name – Dose - Frequency	Start Date	Change date	Stop date	Estimated Duration
Indication Required:				
Indication Required:				
Indication Required:				

48 Hr Review: Contd. Abx use indicated: Y N Can broadness of coverage be reduced: Y N Can Abx use be more targeted: Y N Culture Results Available: Y N
Is route appropriate: Y N Is dose appropriate: Y N Estimated Total Duration of Abx use: _____ days / wks

MD Signature: **Date:**

Antibiotics - Name – Dose - Frequency	Start Date	Change date	Stop date	Estimated Duration
Indication Required:				
Indication Required:				
Indication Required:				
Indication Required:				
Indication Required:				
Indication Required:				
Indication Required:				

ORGANISMS BEING MONITORED: **URGENT**: *Clostridium difficile (C. difficile), carbapenem-resistant Enterobacteriaceae (CRE) , Neisseria gonorrhoeae* **SERIOUS**: *Multidrug-Resistant Acinetobacter collapsed, Drug-Resistant Campylobacter collapsed, Fluconazole-Resistant Candida collapsed, Extended Spectrum Enterobacteriaceae (ESBL) collapsed, Vancomycin-Resistant Enterococcus (VRE) collapsed, Multidrug-Resistant Pseudomonas Aeruginosa collapsed, Drug-Resistant Non-Typhoidal Salmonella collapsed, Drug-Resistant Salmonella Serotype Typhi collapsed, Drug-Resistant Shigella collapsed, Methicillin-Resistant Staphylococcus Aureus (MRSA) collapsed, Drug-Resistant Streptococcus Pneumoniae collapsed, Drug-Resistant Tuberculosis* **CONCERNING:** *vancomycin-resistant S. aureus, Group A Streptococcus (GAS), Group B Streptococcus (GBS)*