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| **Patient Demographics** | | | | | Antibiotic (AB) Details | | | | | | | | | | | | |
| Actions prior to the administration of antimicrobial therapy  Documentation of clinical indication and agent selection | | | | | | | Actions for ongoing antimicrobial care  Duration review | | | Culture & Sensitivity | | |
| **Date** | **PT.**  **MRN** | **Age** | **Gender** | **Antibiotic**  **Name** | Allergy/  Is reaction of allergy stated?  Y/N | **Diagnosis** | **Dose & Freq.** | Is Rx medical treatment (MT)  Or medical prophylaxis  (MP)  ? | Route  (IV/  PO/  INH.) | Is  clinically indicated or indication on  Medical notes at the time of RX?  Y/N | Is antibiotic  Prescribed  Acc. To local  Guideline/ restricted guideline?  IF off guideline is reason documented in medical notes?  Y/N | If IV, is there switch to PO within 48hrs?  Y/N | If IV- PO switch, is total duration ≤7days?  Y/N | Is there a valid stop/  Review  Date or duration on medical noted?  Y/N | Relevant clinical specimens for culture and sensitivity testing are obtained prior to AB?  Y/N | If Sensitivity  results available,  Is AB  prescribing  acc. to  Positive result?  Y/N | If AB restricted, was an Infectious diseases specialist contacted where necessary?  Y/N |
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**Appendix**

**The Compliance Audit Tool**