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| **Patient Demographics** | Antibiotic (AB) Details |
| Actions prior to the administration of antimicrobial therapyDocumentation of clinical indication and agent selection | Actions for ongoing antimicrobial careDuration 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.) | Isclinically indicated or indication onMedical notes at the time of RX?Y/N | Is antibioticPrescribedAcc. To localGuideline/ 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/ReviewDate or duration on medical noted?Y/N | Relevant clinical specimens for culture and sensitivity testing are obtained prior to AB?Y/N | If Sensitivityresults available,Is ABprescribingacc. toPositive 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**