Individual Antibiotic Use Tool

Resident Name: _____ **Room:**_____ **Date:**_____
Antibiotic Order: _____ **Reason/Diagnosis:** _____
Lab Confirmation of Pathogen: YES ❑ NO ❑ **If yes, Pathogen:** _____

	Yes	No	N/A	Comments
Criteria identified to treat infection				
Diagnostics ordered List:				
Report of diagnostic results communicated to physician timely?				
Were there indications from diagnostics to indicate a change in antibiotic therapy?				
Is the resident on the right antibiotic?				
Is the antibiotic right duration?				
Is the antibiotic the right route?				
Is there evidence of monitoring for effectiveness?				
Is there evidence of monitoring for side effects or adverse consequences?				

Additional information for physician (i.e. resistance patterns, prescribing concerns, etc.)

_____

_____

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_____

Feedback provided to: _____ _____
(Physician Name) (Date)

Signature: _____ _____
(Infection Preventionist) (Date)

❑ Information included in QAA report