IEC
المركز الدولي للرعاية الممتدة
International Extended Care Centre

بالقلب نرعاكم
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Antibiotic Stewardship Review & Approval Form

Patient Name _____ **Patient MRN** _____

Sex: □ Female □Male **Location**: □ B2, □ B3, □ B4. **Date:** / / 2020

Antibiotic Requested: ☐ Moxifloxacin ☐ Levofloxacin ☐ Piperacillin/Tazobactam ☐ Cefepime ☐ Colistin

☐ Meropenem ☐ Imipenem ☐ Caspofungin ☐ Tigecycline

☐ Micafungin ☐ Anidulafungin ☐ Voriconazole ☐ Amphotericin ☐ Linezolid ☐ Amikacin ☐ Acyclovir

Dosage Form: ☐ I.V. ☐ Nebulization ☐ Oral

Dose: _____ Frequency _____ Duration:_____ CrCl: _____ ☐ Dialysis

Indication:

a) **Empirical ☐:** _____

- **Appropriate investigations were obtained:** ☐ Peripheral blood culture ☐Central blood culture ☐ Urine analysis ☐Urine culture ☐ Sputum ☐ Wound ☐Stool for toxin ☐CSF ☐ Chest-X-ray ☐CT

b) **To be reviewed in_____ Days**

C) **Therapeutic ☐**:

- ☐ HAP ☐VAP ☐ Bacteremia ☐UTI ☐Pyelonephritis ☐Candidemia ☐Osteomylities ☐Wound infection ☐ Cellulites ☐ Meningitis ☐ Line Infection ☐ Shunt ☐ Other: _____

Diagnosis:_____

Plan:_____

_____

MRP Name: _____ **Signature:** _____ **Date:** _____

Clinical Pharmacist Name: _____ **Signature:** _____ **Date:** _____

Created By: Maha.M.Alawi, MD, FRCPC, CIC
Revised By: Pharmacy Department Jan, 2020