Antimicrobial Stewardship Feedback Form

Microbiology and antimicrobial orders were reviewed and the following is suggested to optimize therapy:

Current regimen: ____

☐ No change recommended	
☐ Recommendation type – see details below:	
☐ Dose optimization ☐ Parenteral to oral route change ☐ Duration of therapy optimization ☐ Stop antimicrobial therapy ☐ ID consult	☐ Narrow spectrum of antimicrobial therapy ☐ Broaden spectrum of antimicrobial therapy ☐ Antibiotic change due to equivalent efficacy and decreased cost
Antimicrobial Assessment:	
Recommendation(s):	

These suggestions are not a substitute for an Infectious Diseases consult.

Pharmacist's name	Print:	Signature:	Date/Time

Do you agree with the above recommendation(s)?

☐ Yes. Please sign below to initiate new order.

☐ No. Specific reason: ____

____

PRESCRIBER'S SIGNATURE: ____________________PRINTED NAME: _________________Date _________ Time ________

ORDER TRANSCRIBED	FAX/SCAN TO PHARMACY
Date: ___________ Time: ___________ Init ___________	Date: ___________ Time: ___________ Init ________