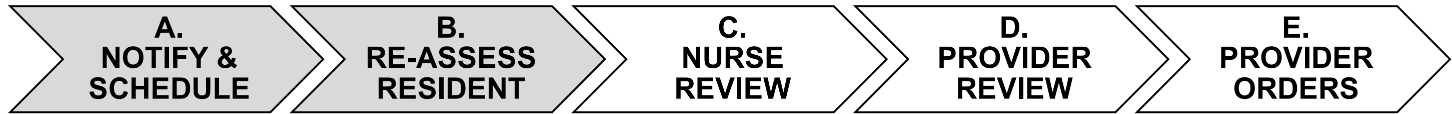
# ANTIBIOTIC REVIEW



Resident Name ______________________________ Room/Bed ________________ Date _____ /_____ /_____ Time____________




| A. NOTIFY PRIMARY PROVIDER IF NEEDED | SCHEDULE PRIMARY PROVIDER REVIEW |
|---|---|
| ☐ Primary provider notified. Date & time: ____________<br>☐ Not applicable, antibiotic prescribed by primary provider | Review date & time: ________________<br>Review mode: ☐ on-site ☐ phone ☐ fax |

## ANTIBIOTIC PRESCRIBING SUMMARY

Who prescribed the antibiotic?

- ☐ Cross-covering provider
- ☐ Emergency Department provider
- ☐ Primary care provider

Which antibiotic(s) was prescribed?

Antibiotic: ___________ Dose: _______ Frequency: ________ Days: ____ Start: ________

Antibiotic: ___________ Dose: _______ Frequency: ________ Days: ____ Start: ________
mm/dd/yy

Is the resident on Coumadin? ☐ No ☐ Yes

Antibiotic allergies (Leave blank if none)

1. ________________________________
2. ________________________________
3. ________________________________

What type of infection is being treated? (check all that apply)

- ☐ Unsure
- ☐ Urinary tract infection (UTI)
- ☐ Pneumonia
- ☐ Bronchitis or COPD exacerbation
- ☐ Aspiration event
- ☐ Cellulitis
- ☐ Wound infection
- ☐ Clostridium difficile

Other:

## B1. RESIDENT CONDITION

**Original Signs & Symptoms** (before antibiotic start)

☐ Fever

☐ Localizing symptoms (e.g., pain with urination, cough): ____________
______________________________
______________________________

☐ Non-localizing symptoms (e.g., confusion, fall): _________________
______________________________
______________________________

**Any New Signs & Symptoms** (since antibiotic start)

☐ Fever

☐ Localizing symptoms (e.g., pain with urination, cough): ___________
______________________________
______________________________

☐ Non-localizing symptoms (e.g., confusion, fall): ________________
______________________________
______________________________

**Today's Vital Signs**

| | |
|---|---|
| Max Temp in past 24 hrs | ______ |
| Lowest Blood Pressure | ___/___ |
| Highest Pulse Rate | ______ |
| Highest Respiratory Rate | ______ |
| Lowest Oxygen Saturation | ______ |

**Other notes:**

**Have the original signs & symptoms been resolved? ☐ No ☐ Yes**

## B2. DIAGNOSTIC TEST RESULTS

**Lab Results**

1. White blood cell count: _______
2. Creatinine level: _______
3. BUN level: ________
4. GFR: _______
5. If diabetic, are the resident's blood sugars higher than normal? ☐ Not applicable ☐ No ☐ Yes

**Cultures**

Were any cultures ordered? ☐ No ☐ Yes

If yes, what cultures were performed? (check all that apply)

☐ Urine culture ☐ Respiratory culture

☐ Wound culture

Other:________________________________

Was resistance identified to any tested antibiotics?

☐ No ☐ Yes (attach copy of report to this form)

**Other relevant lab results** (Note: an *abnormal* urinalysis is a poor predictor of infection in the nursing home population. Do not include)

**Imaging**

Were any imaging studies done?

☐ No ☐ Yes (attach copy of report to this form)

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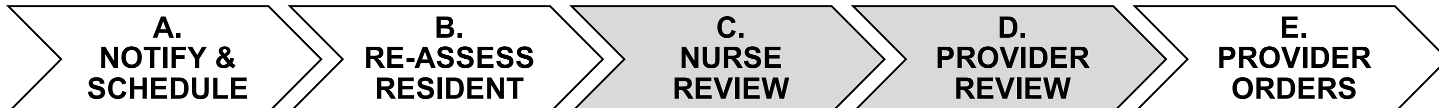
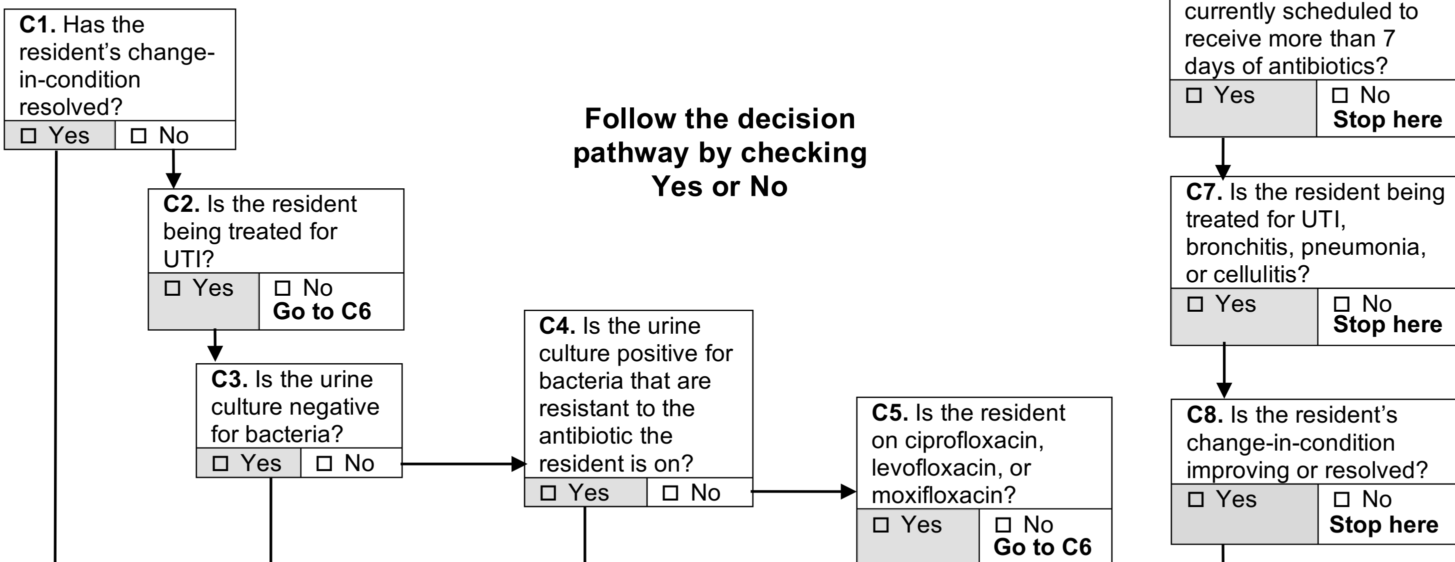
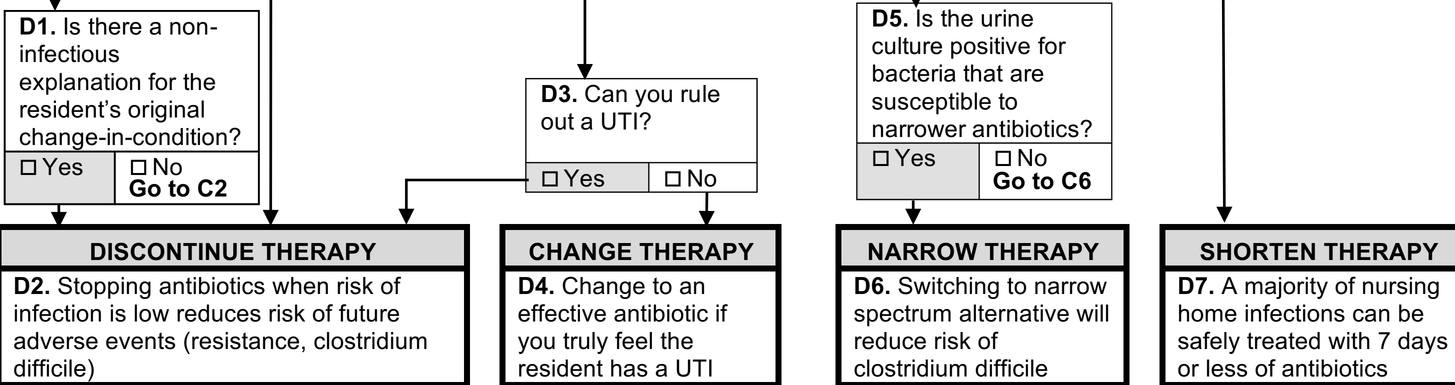


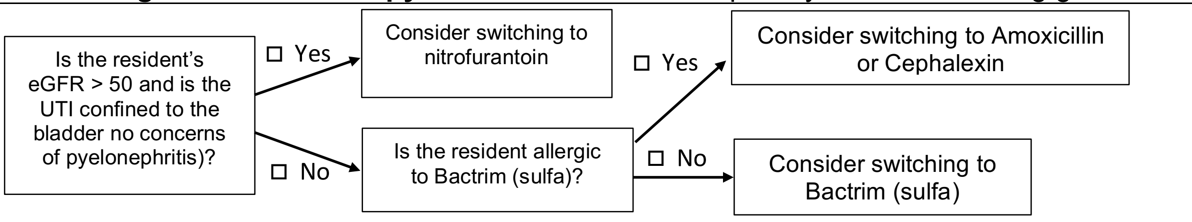

**NURSE FILLS OUT THIS SECTION**




**PROVIDER FILLS OUT THIS SECTION**

**Narrowing Antibiotic Therapy:** consider culture susceptibility and the following guide:




**Short-Course Antibiotic Therapy** (7 days or less)

- As effective as longer (>7 days) courses of antibiotics when treating cystitis, non-purulent cellulitis, acute exacerbations of chronic bronchitis (AECB) and uncomplicated pneumonia.
- Longer treatment may be indicated for infections involving the upper urinary tract (pyelonephritis), prostate or complicated wound infections.

**Ref: (1)** Lutters et al. *Cochrane Database Syst Rev* 2008; (3): CD001535 **(2)** Hepburn et al. *Arch Intern Med* 2004; 164(15): 1669-74 **(3)** Rafailidis et al. *Infect Dis Clin N Am* 2009; 23(2): 269-76

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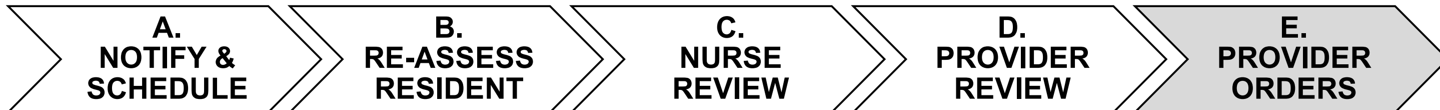


## PROVIDER ORDERS

☐ **CONTINUE.** No change to current antibiotic orders.

Reason:______________________________________________________________________________

______________________________________________________________________________________

☐ **DISCONTINUE.** Discontinue current antibiotic orders.

☐ **CHANGE or** ☐ **NARROW.** Discontinue current antibiotic orders and start new antibiotic(s)

Antibiotic: _____________ Dose: ________ Frequency: __________ Days: ____

Antibiotic: _____________ Dose: ________ Frequency: __________ Days: ____

☐ **SHORTEN.** Continue current antibiotic but change the stop date to __________________

**NURSING NOTES:**



Questions or comments about this form? Email Therese Van Male at vanmale@wisc.edu