**ANTIMICROBIAL STEWARDSHIP RECOMMENDATION FORM**

**Disclaimer:** This recommendation is NOT a formal Infectious Diseases consultation and
DOES NOT substitute for one when indicated. Please use clinical judgment.

**SECTION A**

**Current Antimicrobial Therapy**

|  |  |  |
| --- | --- | --- |
| Antimicrobial Regimen | **Indication\*** | **Start Date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

 \* as interpreted by the Antimicrobial Stewardship Personnel

**Recommendation Type**

□ Infectious Diseases consult □ Addition of therapy □ Discontinue redundant therapy

□ Dosage change □ Alternate therapy □ Discontinue therapy

□ Route of administration change □ Streamline therapy □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suggested Order Change:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pager:\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pager:\_\_\_\_\_\_\_\_\_\_\_

Pharmacist, Antimicrobial Stewardship Program Physician, Antimicrobial Stewardship Program

**SECTION B (TO BE COMPLETED, DATED, AND SIGNED BY PRESCRIBER)**

□ Accept the suggested order change and process order as written above.

□ Accept the suggested order change with the following modifications:

□ Reject the suggested order change due to the following reason(s):

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_