

DAY 3 EMPIRIC ANTIMICROBIAL REVIEW TOOL

Date: _____

Review of initial infection diagnosis:

Initial infection diagnosis:
 Is the initial diagnosis still correct? Yes No
 If not, new infection diagnosis:

Microbiology results:

	No growth	Positive C&S
Blood culture	<input type="checkbox"/>	_____
Sputum	<input type="checkbox"/>	_____
Urine	<input type="checkbox"/>	_____
Wound	<input type="checkbox"/>	_____
Viral screen	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	_____
Procalcitonin	<0.25 <input type="checkbox"/>	>=0.25 <input type="checkbox"/> ITU<0.5 <input type="checkbox"/>

Relevant imaging results:

Test	Results:

In patients on IV antibiotics, is an oral switch possible? 4 Yes's = switch

Does the patient meet ALL of the ACED criteria?	Yes	No
A - Afebrile >24hours	<input type="checkbox"/>	<input type="checkbox"/>
C - Clinically improving over the past 24 hours	<input type="checkbox"/>	<input type="checkbox"/>
i. Improving signs and symptoms of infection	<input type="checkbox"/>	<input type="checkbox"/>
ii. No unexplained tachycardia	<input type="checkbox"/>	<input type="checkbox"/>
iii. Blood pressure stable with no unexplained hypotension	<input type="checkbox"/>	<input type="checkbox"/>
iv. Respiratory rate normal	<input type="checkbox"/>	<input type="checkbox"/>
v. High white cell count is falling	<input type="checkbox"/>	<input type="checkbox"/>
vi. C-reactive protein (CRP) is falling	<input type="checkbox"/>	<input type="checkbox"/>
E - Eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>
i. Can tolerate oral fluids or have fluids via a tube into the gut	<input type="checkbox"/>	<input type="checkbox"/>
ii. No signs of malabsorption	<input type="checkbox"/>	<input type="checkbox"/>
iii. There is a suitable oral product available	<input type="checkbox"/>	<input type="checkbox"/>
D - Not suffering from certain Deep-seated/high-risk infections	<input type="checkbox"/>	<input type="checkbox"/>
▪ Liver abscess ▪ Osteomyelitis, septic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
▪ Inadequately drained abscesses or empyema ▪ Cavitating pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
▪ <i>Staphylococcus aureus</i> bacteraemia	<input type="checkbox"/>	<input type="checkbox"/>
▪ Severe necrotising soft tissue infections	<input type="checkbox"/>	<input type="checkbox"/>
▪ Severe infection during chemotherapy related neutropenia	<input type="checkbox"/>	<input type="checkbox"/>
▪ Infected implants/prosthesis ▪ Meningitis/encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
▪ Intracranial abscesses ▪ Mediastinitis ▪ Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>

Antibiotic plan: (please ensure the antibiotic is correctly prescribed on the drug chart, with indication and duration, plus a microbiology code is needed for a restricted antibiotic)

Antibiotic(s):	Route:	Dose and frequency:	Duration:	Microbiology code:

Advice from: micro / infectious diseases / antimicrobial pharmacist (circle)

Reason for continuing same IV AB (if applicable):

**** Consider stopping antibiotics if no clinical and no microbiological evidence of infection ****

Your details:

Name:	Signature:	Designation & specialty:	Contact number: