**TIPCU Antimicrobial Event Sheet**

Department of Health and Human Services



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| **Hospital Name:** | **Audit month and year:** | | | |
| **Patient identification number:** | **DOB: / /** | **Gender: M F O** | **Admission: / /** | **Discharge: / /** |

| **Start date** | **Finish date** | **Antimicrobial** | **Route** | **Dose** | **Frequency** | **Indication**  **Documented**  **Y/N** | **Documented or presumed indication**  If respiratory tract infection, specify syndrome  e.g. community associated pneumonia (mild, moderate or severe), aspiration pneumonia, infective exacerbation of COPD, bronchitis |
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| **Allergies and adverse drug reactions to ANTIMICROBIALS** | nil known | **not** documented | **present** |
| If present, specify drug and nature of reaction: | | | |

| **Microbiology not collected collected** | Date of Specimen | Site of Specimen | Result |
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Name of person who completed the form ……………………………………………………….. Signature ……………………………………………………..

Name of prescriber ……………………………………………………….. Signature ……………………………………………………..