

**Medical Center
Department of Pharmacy Antibiotic Streamlining
Communication Form**

Dear Doctor:

The following information is presented to you for your review and evaluation regarding this patient's antimicrobial therapy. *These recommendations are based primarily on laboratory data and your clinical judgement of the patient's condition should be used to determine the best treatment course for the patient.*

Patient Name: _____ Room: _____

Allergies:

Current Culture and Sensitivity Data:

Date	Source	Culture and Sensitivity Results

Current Antibiotic Regimen:

Dates	Antibiotic	Days of Therapy

Clinical Data:

Date	Data	Findings
	WBC	
	CXR	
	Tmax	

Please consider the following change(s) to the antibiotic regimen:

*If infection has been ruled out, please consider
discontinuing antimicrobial therapy*

If you have questions or wish to discuss this recommendation, please call the pharmacy at xxx-xxxx.

Thank you for your consideration. _____ RPh ____/____/____ Time:

NOTE: THIS IS NOT A PART OF THE PATIENT'S PERMINANT MEDICAL RECORD