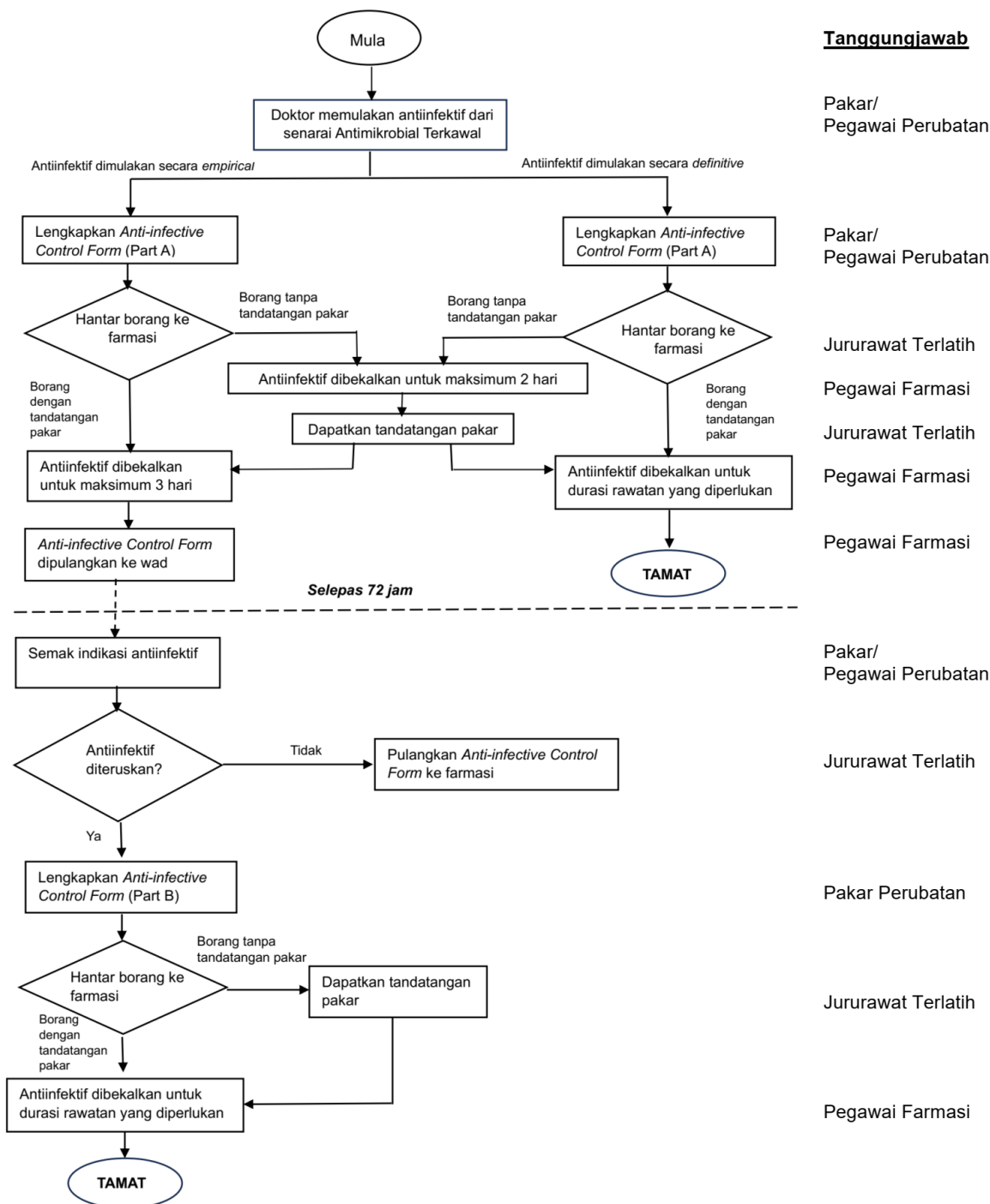


LIST OF ANTI-INFECTIVES INVOLVED

1. IV Ertapenem
2. IV Imipenem/Cilastatin
3. IV Meropenem
4. IV Vancomycin

5. IV Anidulafungin
6. IV Caspofungin
7. IV Micafungin
8. Other controlled anti-infective: _____

PROTOCOL FOR INDENTING LISTED ANTI-INFECTIVES:



References:



National Antimicrobial Guideline (NAG) 2024, 4th Edition



Guide to Antimicrobial Therapy in the Adult ICU 2023



HRPB Antimicrobial Guideline 2023, 2nd Edition

**ANTI-INFECTIVE FORM,
HOSPITAL RAJA PERMAISURI BAINUN, IPOH**

** One form is for one drug only, please attach this form together with prescription before sending to pharmacy*

PART A: INITIATION REVIEW

Patient's name		Age	
MRN		Ward and Bed No.	
Admission Date		Weight (kg)	
Anti-infective requested (dose and frequency)		Date of drug started	
Diagnosis			
Indication	☐ Nosocomial infection ☐ Community-acquired infection		
Treat as:	☐ Empirical treatment (Please complete Part B after 72 hours) ☐ Based on C&S results. Please specify: - Date of sampling: _____ Type of sample: _____ Microorganism: _____		
Culture sent prior to start antibiotic	☐ Blood ☐ Sputum/ETT/Urine/Tissue/Pus/CSF ☐ Others		
Prescriber's signature and stamp:		Specialist's signature and stamp:	

PART B: 72-HOUR REVIEW (only applicable for empirical antibiotics)

Antibiotic supply will be **DISCONTINUED** if this form is **NOT COMPLETED** and returned to Pharmacy Department after 72 hours.

Justification for continuation	☐ Empirical treatment. C&S results not available yet ☐ Based on C&S results. Please specify: - Date of sampling: _____ Type of sample: _____ Microorganism: _____ ☐ C&S results show no growth but treatment is clinically indicated		
Dose and frequency		Planned duration	
Date of review		Specialist signature and stamp	
Pharmacist's comment		Pharmacist's signature and stamp	

Please send this form back to the Pharmacy Department even if the treatment is discontinued