Client Risk Assessment
Antibiotic Monitoring Form

ANTIBIOTIC GUARDIAN

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Allergies/sensitivities checked? YES/NO				**Antibiotic Name:**
RECORD ALLERGY OR NO KNOWN ALLERGY				**Indication for use:**
				Sample obtained (date/type)**:**
Name:				**Result received? YES/NO Date:**
Date of Birth:				**Start date:** **End date:**
Once daily	**Twice daily**	**Three times daily**	**Four times daily**	**Special instructions:** e.g. half hour before food or evenly spaced throughout 24 hours

Date	Amount given	Balance	**Comments:** e.g. symptoms/improvements/deterioration/ adverse reactions

Continue on next page

Date	Amount given	Balance	**Comments:** e.g. symptoms/improvements/deterioration/ adverse reactions

Communicate with the patient's General Practitioner and other care providers:
Record baseline observations, monitor for adverse reactions to antibiotics; if symptoms persist please contact the patient's GP for further assessment.

Log below any communications with GP

Date	Comments	Signature/role

Continue on next page

Log below any communications with GP

Date	Comments	Signature/role