**Antibiotic Monitoring Form**

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| **Name:** | | | | **Date of Birth:** |
| **Antibiotic Name/dose:** | | | | **Indication for use:** |
| **Total number of tablets:** | | | | **Specimen sent:** |
| **Date commenced:** | | | | **Result received:** |
| **Frequency to be given tick as appropriate**: | | | | **Date course completed:** |
| Once daily | Twice daily | Three times daily | Four times daily | **Special instructions:**  e.g. ½ hour before food or evenly spaced throughout 24hrs |

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| **Date** | **Amount given** | **Balance** | **Comments:**  e.g. any improvements/deterioration/adverse reactions |
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**Contact GP if antibiotics do not appear to have been effective**

**Contact GP immediately if there are any adverse reactions to antibiotics**

**Log below any communications with GP**

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| **Date** | **Comments** | **Signature** |
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