

eAppendix 2 Antimicrobial Stewardship Follow-up Template

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Date and time:

Name/Relationship of person(if other than patient):

Antibiotic details:

Name

Strength

Quantity prescribed

Frequency

Date prescribed

Duration of therapy

Completion of antibiotic regimen: YES – NO

Resolution of symptoms: YES – NO

Side effects experienced: YES – NO

Explain if Yes

Patient was instructed to report to urgent care or primary care if symptoms return. Patient provided with time to ask questions if needed.