**Feedback Form for Providers:**

**Newborn Antibiotic Prescribing**

***Use this form to provide feedback to providers regarding newborn antibiotic administration***

Infant ID/Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infection: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antibiotic(s) prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Infant situation **did meet criteria** for initiation of antibiotics
	+ Antibiotic selection *was* consistent with hospital’s first line treatment protocol
	+ Antibiotic selection *was not* consistent with hospital’s first line treatment protocol
* Infant situation **did NOT meet criteria** for initiation of antibiotics

**Specific feedback from Medical Director:**

**If desired, please provide comments for the Medical Director and return to the unit’s nurse manager:**

 Thank you for your commitment to antibiotic stewardship and quality!