Complete the shaded boxes before handing in for referral

MICROBIOLOGY - PHARMACY REFERRAL FORM GRH & CGH

2015

Date	Patient name	MRN	Ward	Consultant	Name pharmacist

Reason for referral

Antibiotic allergies

Drug Name: Reaction:	

Anti-infectives currently prescribed

Name	Dose	Frequency	Route	Start date/ Day of treatment	Indication

Anti-infectives prescribed recently

Name	Dose	Frequency	Route	Start date/ course length	Indication

Bloods

Date	WCC	CRP	Temp	eGFR	LFT's (if relevant)

Microbiology

Date	Blood cultures	MRSA	Urine	Faeces	

Other relevant information NBM, NG tube, Catheter foreign material

Date
Summary of actions/advice
Date
Summary of actions/advice
Date
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