

HIGH-RISK DRUG CLASS AUDIT

INSTRUCTIONS: Check (✓) the box(es) that correspond to the high-risk drug class ordered for this resident. Note: The resident may have orders for more than one (1) drug class. Record the information for each item of that drug class. Use the reverse side for Additional Comments/Notes as appropriate. The clinician conducting the audit will sign and date as indicated as well as any additional comments or notes on the reverse side.

HIGH-RISK DRUG CLASS	NAME OF DRUG	DIAGNOSIS OR INDICATION FOR DRUG	DOSAGE AND FREQUENCY	DATE DRUG INITIATED	PRESCRIBING PHYSICIAN/ PHYSICIAN EXTENDER	LOCATION OF DIAGNOSIS/ INDICATION DOCUMENTATION	LAB(S)/ MONITORING FOR ADVERSE REACTION(S) IN PLACE
<input type="checkbox"/> Antipsychotic							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Antianxiety							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Antidepressant							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Anticoagulant (warfarin, heparin, low-molecular weight heparin)							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Antibiotic							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Diuretic							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Opioid							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Antiplatelet							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
<input type="checkbox"/> Hypoglycemic (includes insulin)							<input type="radio"/> No <input type="radio"/> Yes
Action(s) Needed/Comments:							<input type="checkbox"/> Cont.'d on reverse
Auditor Signature/Title: _____					Date: _____		

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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ADDITIONAL COMMENTS/NOTES

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NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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