

# National Bone & Joint Infection Registry

PLEASE RETURN THIS FORM TO YOUR BAJIR ADMINISTRATOR FOR DETAILS TO BE ADDED TO THE REGISTRY

## BAJIR – SYSTEMIC MEDICAL MANAGEMENT



**PATIENT ID** (Label preferred):

(Minimum required:  
Name, D.O.B, NHS Number)

**NAME OF PRESCRIBING DOCTOR:**

Please complete all parts by ticking the most appropriate box.

These reflect the drop down options in the registry and there is no facility for free-text unless stated

**DATE ANY PREVIOUS TREATMENT STOPPED:** \_\_\_\_\_

**DATE NEW TREATMENT TO COMMENCE:** \_\_\_\_\_ **INTENDED DURATION OF TREATMENT :** \_\_\_\_\_ WEEKS

**DELIVERY:**

ORAL

I.V

### **ORAL ANTIBIOTICS REGIME:**

- |  |   |                                       |                                       |   |
|--|---|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> AMOXICILLIN       | <input type="checkbox"/> FLUCLOXACILLIN | <input type="checkbox"/> CO-AMOXICLAV | <input type="checkbox"/> CLINDAMYCIN  | <input type="checkbox"/> CLARITHROMYCIN |
| <input type="checkbox"/> AZITHROMYCIN      | <input type="checkbox"/> FUSIDIC ACID   | <input type="checkbox"/> DOXYCYCLINE  | <input type="checkbox"/> MOXIFLOXACIN | <input type="checkbox"/> CIPROFLOXACIN  |
| <input type="checkbox"/> TRIMETHOPRIM      | <input type="checkbox"/> CO-TRIMOXAZOLE | <input type="checkbox"/> RIFAMPICIN   | <input type="checkbox"/> LINEZOLID    | <input type="checkbox"/> PRISTINAMYCIN  |
| <input type="checkbox"/> ANTI-TB TREATMENT | <input type="checkbox"/> METRONIDAZOLE  | <input type="checkbox"/> ANTIFUNGAL   |                                       |   |

### **I.V ANTIBIOTICS REGIME:**

- |  |   |   |                                       |                                      |
|--|---|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> BENZYL PENICILLIN | <input type="checkbox"/> AMOXICILLIN                | <input type="checkbox"/> FLUCLOXACILLIN | <input type="checkbox"/> CO-AMOXICLAV | <input type="checkbox"/> CEFTRIAXONE |
| <input type="checkbox"/> PIPERACILLIN      | <input type="checkbox"/> TAZOBACTAM                 | <input type="checkbox"/> CEFTAZIDIME    | <input type="checkbox"/> ERTAPENEM    | <input type="checkbox"/> MEROPENEM   |
| <input type="checkbox"/> VANCOMYCIN        | <input type="checkbox"/> TEICoplanin                | <input type="checkbox"/> DAPTOMYCIN     | <input type="checkbox"/> GENTAMICIN   | <input type="checkbox"/> TIGECYCLINE |
| <input type="checkbox"/> METRONIDAZOLE     | <input type="checkbox"/> OTHER (Please state) _____ |   |                                       |                                      |

**PHAGE TREATMENT:** (Please give details)