PAEDIATRIC MEDICINE CHART ..... of .....

Facility/Service:_____

Ward/Unit:.....

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain/P.C.A. ☐ IV Heparin
☐ Inhalation ☐ Chemotherapy ☐ Palliative Care ☐ Other

ONCE ONLY MEDICINES

Date Prescribed	Medicine (Print Generic Name)	Route	DOSE	Date/Time to be given	Prescriber Signature	Prescriber Print Name	DOSE calc e.g. mg/kg per DOSE	Given by	Date/Time Given	Pharm

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medicine (use Generic Names) Print	Route	Dose	Frequency	Nurse Initials Nr 1/Nr 2		Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/Given by:	Time/Given by:	Time/Given by:	Time/Given by:

Medicines taken Prior to Presentation to Hospital (Prescribed, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N

Medicine & Formulation	Dose & Frequency	Duration	Medicine & Formulation	Dose & Frequency	Duration

NOT FOR ADMINISTRATION

Doctor/GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

NATIONAL PAEDIATRIC LONG STAY MEDICINE CHART
Version 2, December 2007

Hospital Only Prescription

NOT A VALID ORDER UNLESS LEGIBLE

AS REQUIRED "PRN" MEDICINES

Attach ADR Sticker

See front page for details

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVER LEAF

UR No.:

Family Name:

Given Names:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

D.O.B.: Sex: ☐ M ☐ F

Ward/Unit:_____ **Weight (kg)**

1st Prescriber to Print Patient Name and Check Label Correct:.....

Each PRN block:

Date | Medicine (Print Generic Name) | Date
Route | DOSE | Hourly Frequency **PRN** | Max DOSE/24 hrs | Time
Pharmacy/Additional Information | DOSE
Indication | Dose Calculation (e.g. mg/kg per DOSE) | Route
Prescriber Signature | Print Name | Contact/Pager | Sign

Continue on discharge Yes / No
Dispense Yes / No
Duration?.....days/Qty?.....

Date .....
Pharmacist.....
Pager.....
Print Name.....
Prescriber's Signature.....

BINDING MARGIN - DO NOT WRITE

Hospital Only Prescription

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

Sign .....Print.....Date.....

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVER LEAF

UR No.:

Family Name:

Given Names:

D.O.B.: Sex: ☐ M ☐ F

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

1st Prescriber to print patient name & check label correct:

.....

Weight (kg)

B.S.A.(m^2).....

Height (cm).....

Gestational Age (wks).....

REGULAR MEDICINES

YEAR 20_____ **DATE & MONTH** →

DOCTOR MUST ENTER administration times ↘

Each medicine block:

Date	Medicine (Print Generic Name)	Tick if Slow Release
Route	**DOSE**	Frequency & now enter times →
Pharmacy/Additional Information		
Indication	Dose Calculation (e.g. mg/kg per DOSE)	
Prescriber Signature	Print Name	Contact/Pager

Continue on discharge Yes / No
Dispense Yes / No
Duration?.....days/Qty?.....

Date.....

Pharmacist.....

Date.....

Pager.....

Print Name.....

Prescriber's Signature.....

Pharmacist Review:

BINDING MARGIN - DO NOT WRITE

NATIONAL PAEDIATRIC LONG STAY MEDICINE CHART,Version 2: 12/07 - 12188

NOT A VALID ORDER UNLESS LEGIBLE

Hospital Only Prescription

RECOMMENDED ORAL ADMINISTRATION TIMES
GUIDELINES ONLY

Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Four times a day	QID	0600	1200	1700	2100

Tick if Slow release — SR=Sustained or modified release formulation. If scored tablet, then half can be given. Dose must be swallowed without crushing.

REASON FOR NOT ADMINISTERING Codes MUST be circled	
Absent	(A)
Fasting	(F)
Refused - Notify Prescriber	(R)
Vomiting	(V)
On leave	(L)
Not available - obtain supply or contact Prescriber	(N)
Withheld - Enter reason in Clinical Record	(W)
Self Administration	(S)
Parent/Carer Administration	(P)