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:

D.O.B.: Sex: ☐ M ☐ F

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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

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

NOT A VALID ORDER UNLESS LEGIBLE

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.....

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?.....

Pharmacist.....

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?.....

.....Pager.....Date.....

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?.....

.....Print Name.....

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?.....

Prescriber's Signature.....

BINDING MARGIN - DO NOT WRITE

Hospital Only Prescription

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

BINDING MARGIN - DO NOT WRITE

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:

Paediatric National Short Stay Med Chart: 12/06 - 12187

PAEDIATRIC MEDICINE CHART

Hospital Only Prescription

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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.....

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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 →

PRESCRIBER MUST ENTER ADMINISTRATION TIMES

NOT A VALID ORDER UNLESS LEGIBLE

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.....

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	0800	1200	1700	2100

Tick if Slow release — SR=Sustained or modified release formulation. If tablet is scored, 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)

Pharmacist Review:

Hospital Only Prescription

REGULAR MEDICINES

YEAR 20_____ DATE & MONTH →

PRESCRIBER MUST ENTER ADMINISTRATION TIMES

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:

Hospital Only Prescription