Cut Off Section

PAEDIATRIC MEDICATION CHART No. ..... of .....

Facility/Service: .....

Ward/Unit: .....

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ IV Heparin
☐ Inhalation ☐ Palliative Care ☐ Chemotherapy ☐ Other

ONCE ONLY MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	DOSE	Date/Time to be Given	Prescriber Signature	Prescriber Print Your Name	DOSE calc eg. mg/kg per DOSE	Given by	Date/Time Given	Pharm

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

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials NR1/NR2		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 and formulation	Dose and frequency	Duration	Medicine and formulation	Dose and frequency	Duration

NOT FOR ADMINISTRATION

Doctor/GP: **Community Pharmacy:**

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

PAEDIATRIC LONG STAY MEDICATION CHART PAEDIATRIC

AFFIX PATIENT IDENTIFICATION LABEL HERE

URN:
Family name:
Given names:
Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Date of birth: Sex: ☐ M ☐ F

***First Prescriber* to Print Patient Name and Check Label Correct:** .....

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Weight (kg)

Ward/Unit: .....

NOT A VALID ORDER UNLESS LEGIBLE

Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											
Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											
Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											
Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											
Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											
Date	Medication (Print Generic Name)			Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
Route	**DOSE**	Hourly Frequency **PRN**	Max Dose/24 hrs	Time											
Pharmacy/Additional information				**Dose**											
Indication	**DOSE** Calculation (eg. mg/kg per dose)			Route											
Prescriber Signature	Print Your Name	Contact/Pager		Sign											

Prescriber's signature: ..... Print your name: ..... Pager: .....

DO NOT WRITE IN THIS BINDING MARGIN

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

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

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

URN:

Family name:

Given names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Date of birth: Sex: ☐ M ☐ F

***First Prescriber* to print patient name and check label correct:**

Weight (kg)

BSA (m^2):..... Height (cm):.....

Gestational age (wks):.....

Cut Off Section

REGULAR MEDICATIONS

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 (eg. mg/kg per dose)

Prescriber Signature | Print Your Name | Contact/Pager

Continue on discharge? Yes / No

Dispense? Yes / No

Duration:.....days Qty:.....

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Your Name | Contact/Pager

Continue on discharge? Yes / No

Dispense? Yes / No

Duration:.....days Qty:.....

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Your Name | Contact/Pager

Continue on discharge? Yes / No

Dispense? Yes / No

Duration:.....days Qty:.....

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Your Name | Contact/Pager

Continue on discharge? Yes / No

Dispense? Yes / No

Duration:.....days Qty:.....

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Your Name | Contact/Pager

Continue on discharge? Yes / No

Dispense? Yes / No

Duration:.....days Qty:.....

Pharmaceutical Review:

Date:.....

Pharmacist:.....

Date:.....

Pager:.....

Print your name:.....

Prescriber's signature:.....

RECOMMENDED 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	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

Tick if Slow Release

SR = Sustained, modified or controlled 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 administered	S
Parent/Carer administered	P

DO NOT WRITE IN THIS BINDING MARGIN

NOT A VALID ORDER UNLESS LEGIBLE