Cut Off Section

MEDICATION Chart No. ..... **of** .....

Facility/Service: .....

Ward/Unit: .....

ADDITIONAL CHARTS

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

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of Dose	Prescriber/Nurse Initiator (NI) Signature	Prescriber/Nurse Initiator (NI) Print Your Name	Given By	Time Given	Pharmacy

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 medications brought in? ☐ Y ☐ N Administration Aid (specify) .....

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

NOT FOR ADMINISTRATION

GP: **Community Pharmacy:**

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

LONG STAY MEDICATION CHART

Check if patient has another Medication Chart

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

YEAR: 20.....

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Date:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															
Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Pharmacist:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															
Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Date:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															
Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Date:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															
Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Print your name:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															
Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ....days Qty:....	Prescriber's Signature:
Route	Dose Hourly Frequency		Max Dose/24 hrs	Time															
Indication		Pharmacy		Dose / Route															
Prescriber Signature	Print Your Name		Contact	Sign															

DO NOT WRITE IN THIS BINDING MARGIN

Check if patient has another Medication Chart

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):..... Height(cm):.....

Cut Off Section

REGULAR MEDICATIONS

YEAR: 20..... **DATE & MONTH** →

Date	*WARFARIN*	(Marevan/Coumadin) select brand
Route	Prescriber to enter individual doses	Target INR Range
Indication		Pharmacy
Prescriber Signature	Print Your Name	Contact

INR Result	
Dose	mg mg mg