

Cut Off Section

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: _____
 Date of birth: _____ Sex: M F

NOT A VALID
 PRESCRIPTION UNLESS
 IDENTIFIERS PRESENT

First Prescriber to Print Patient Name and Check Label Correct: Weight(kg):..... Height(cm):.....

REGULAR MEDICATIONS
 YEAR 20 DATE & MONTH →

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Drug level	Time level taken	Dose	Route	Frequency	Prescriber	Time to be given:	Time given	Continue on discharge? Yes / No	Dispense? Yes / No	Duration: days Qty:

Prescriber Signature Print Your Name Contact

WARFARIN (Marevan/Coumadin)
 select brand

Date	Route	Prescriber to enter individual doses	Target INR Range	Dose	Indication	Pharmacy	Prescriber	Continue on discharge? Yes / No	Dispense? Yes / No	Duration: days Qty:

1600 (Nurse 1)
 Nurse 2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes / No	Dispense? Yes / No	Duration: days Qty:

Pharmaceutical Review:

RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY

Time	Frequency	Time	Time	Time	
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

WARFARIN EDUCATION RECORD

Patient Educated by:.....
 Sign:.....
 Date:.....
 Given Warfarin Book:.....
 Sign:.....
 Date:.....

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

REASON FOR NURSE NOT ADMINISTERING
 Codes MUST be circled

- Absent (A)
- Fasting (F)
- Refused - notify Dr (R)
- Vomiting (V)
- On leave (L)
- Not available - obtain supply or contact Dr (N)
- Withheld - enter reason in clinical record (W)
- Self Administered (S)

Pharmacist: Date:
 Print your name:
 Print your name:

REGULAR MEDICATIONS
 YEAR 20 DATE & MONTH →

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes / No	Dispense? Yes / No	Duration: days Qty:

Pharmaceutical Review: