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: .....
Route	Dose Hourly Frequency **PRN**	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: .....
Route	Dose Hourly Frequency **PRN**	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: .....
Route	Dose Hourly Frequency **PRN**	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: .....
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Indication	Pharmacy		Dose															
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Prescriber Signature	Print Your Name	Contact	Sign															

Date	Medication (Print Generic Name)		Date															Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
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Prescriber Signature	Print Your Name	Contact	Sign															

Date	Medication (Print Generic Name)		Date															Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency **PRN**	Max Dose/24 hrs	Time															
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Prescriber Signature	Print Your Name	Contact	Sign															

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Route	Dose Hourly Frequency **PRN**	Max Dose/24 hrs	Time															
Indication	Pharmacy		Dose															
			Route															
Prescriber Signature	Print Your Name	Contact	Sign															

Date: ..... Pharmacist: .....

Date: ..... Print your name: .....

Prescriber's Signature: .....

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Cut Off Section

Facility/Service: .....

Ward/Unit: .....

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

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 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:

National Medication Chart – 11/2008 – © Commonwealth of Australia 2005 – As amended 2008

MEDICATION CHART

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:

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):.....

REGULAR MEDICATIONS

YEAR 20..... DATE & MONTH →

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name)

Route | Frequency

Prescriber to enter dose times and individual dose

Indication | Pharmacy

Prescriber Signature | Print Your Name | Contact

Drug level

Time level taken

Dose

Prescriber

Time to be given: .....

Time given

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

Date:

WARFARIN (Marevan/Coumadin) select brand

Date | Route | Prescriber to enter individual doses | Target INR Range | Indication | Pharmacy | Prescriber Signature | Print Your Name | Contact

INR Result

Dose mg mg mg mg mg mg mg mg mg mg mg mg

Prescriber

1600 (Nurse 1)

Nurse 2

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

Pharmacist:

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release
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:.....

Date:

Print your name:

Prescriber's Signature:

Pharmaceutical Review:

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	

WARFARIN EDUCATION RECORD

Patient Educated by:.....

Sign: .....

Date:.....

Given Warfarin Book:.....

Sign: .....

Date:.....

SR = Sustained, modified or controlled release formulation.

Tick if Slow Release

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

REGULAR MEDICATIONS

YEAR 20..... DATE & MONTH →

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release
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:.....

Date:

Pharmacist:

Print your name:

Prescriber's Signature:

Pharmaceutical Review: