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	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

LONG STAY MEDICATION CHART

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:

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 | | | | | | | | | | | | |

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):.....

Cut Off Section

REGULAR MEDICATIONS

YEAR: 20..... **DATE & MONTH** →

Date	*WARFARIN*	(Marevan/Coumadin) select brand	INR Result
Route	Prescriber to enter individual doses	Target INR Range	**Dose** mg
Indication		Pharmacy	Prescriber
Prescriber Signature	Print Your Name	Contact	*1600* (Nurse 1)
DOCTORS MUST ENTER administration times			Nurse 2

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

Date:.....

Pharmacist:.....

Date:.....

Print your name:.....

Prescriber's Signature:.....

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose	Frequency & NOW Enter Times →
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose	Frequency & NOW Enter Times →
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose	Frequency & NOW Enter Times →
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose	Frequency & NOW Enter Times →
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose	Frequency & NOW Enter Times →
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Pharmaceutical Review:

WARFARIN EDUCATION RECORD

Patient Educated by:.....

Sign:.....

Date:.....

Given Warfarin Book:.....

Sign:.....

Date:.....

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 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

DO NOT WRITE IN THIS BINDING MARGIN

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

Check if patient has another Medication Chart

Check if patient has another Medication Chart