

Medication Chart Page 2 of 4

Allergies and adverse drug reactions
See page 1 for details

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: _____

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

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: _____

REGULAR MEDICATIONS

YEAR 20.....		DATE & MONTH →														Continue on discharge? Yes / No	Dispense? Yes / No	Duration:days Qty:		
VARIABLE DOSE MEDICATION																				
Date		Medication (Print Generic Name)		Drug level																
Route		Frequency		Dose																
Indication		Pharmacy		Prescriber																
Prescriber Signature		Print Your Name		Contact		Time to be given:														
						Time given														
Date		WARFARIN (Marevan/Coumadin)		INR Result																
Route		Prescriber to enter individual doses		Target INR Range		Dose														
Indication		Pharmacy		mg mg mg mg mg mg mg mg mg mg mg mg																
Prescriber Signature		Print Your Name		Contact		Prescriber														
						1600 (Nurse 1)														
						Nurse 2														
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																
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																

DO NOT WRITE IN THIS BINDING MARGIN

Pharmacist: _____ Date: _____
 Print your name: _____ Date: _____
 Prescriber's Signature: _____

