

ATTACH ADR STICKER

DIABETIC ON INSULIN

ALLERGIES & ADVERSE REACTIONS (ADR)

Nil known Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

Sign Print Date

UR No.

Family Name:
Given Names:

DOB:

Sex M F

NOT A VALID
PRESCRIPTION UNLESS
IDENTIFIERS PRESENT

DOCTOR MUST SIGNIFY PATIENT IDENTIFICATION

Print Name Signature

Patient Weight kgs Patient Height cms

PRESCRIPTION MEDICATIONS

Date & Month																				
Dosage Times																				

DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath

Date	Patient Name 1st 2nd	<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
Drug (Generic Name)	Route Dose	Frequency
<input type="checkbox"/> Brand substitution not permitted		
Print Prescriber Name	Prescriber No.	Prescriber Signature Contact
Indication	Pharmacy	Quantity Repeats
Discharge Required	Yes / No	Duration/Quantity Dr. Signature

DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath

Date	Patient Name 1st 2nd	<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
Drug (Generic Name)	Route Dose	Frequency
<input type="checkbox"/> Brand substitution not permitted		
Print Prescriber Name	Prescriber No.	Prescriber Signature Contact
Indication	Pharmacy	Quantity Repeats
Discharge Required	Yes / No	Duration/Quantity Dr. Signature

DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath

Date	Patient Name 1st 2nd	<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
Drug (Generic Name)	Route Dose	Frequency
<input type="checkbox"/> Brand substitution not permitted		
Print Prescriber Name	Prescriber No.	Prescriber Signature Contact
Indication	Pharmacy	Quantity Repeats
Discharge Required	Yes / No	Duration/Quantity Dr. Signature

DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath

Date	Patient Name 1st 2nd	<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
Drug (Generic Name)	Route Dose	Frequency
<input type="checkbox"/> Brand substitution not permitted		
Print Prescriber Name	Prescriber No.	Prescriber Signature Contact
Indication	Pharmacy	Quantity Repeats
Discharge Required	Yes / No	Duration/Quantity Dr. Signature

DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath

Date	Patient Name 1st 2nd	<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
Drug (Generic Name)	Route Dose	Frequency
<input type="checkbox"/> Brand substitution not permitted		
Print Prescriber Name	Prescriber No.	Prescriber Signature Contact
Indication	Pharmacy	Quantity Repeats
Discharge Required	Yes / No	Duration/Quantity Dr. Signature

DAY ONLY MEDICATION CHART

MR 94

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats

PHARMACY PRESCRIPTION ORIGINAL			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats

PHARMACY PRESCRIPTION ORIGINAL			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats

PHARMACY PRESCRIPTION ORIGINAL			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats

PHARMACY PRESCRIPTION ORIGINAL			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats

PHARMACY PRESCRIPTION ORIGINAL			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation		Quantity	Repeats

PHARMACY PRESCRIPTION DUPLICATE			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation		Quantity	Repeats

PHARMACY PRESCRIPTION DUPLICATE			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation		Quantity	Repeats

PHARMACY PRESCRIPTION DUPLICATE			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation		Quantity	Repeats

PHARMACY PRESCRIPTION DUPLICATE			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature

PHARMACY PRESCRIPTION	Date	Patient Name 1st _____ 2nd _____		<input type="checkbox"/> PBS <input type="checkbox"/> RPBS <small>(✓) Appropriate box</small>
	Drug (Generic Name)	<input type="checkbox"/> Tick if Slow release	Route	Dose
	<input type="checkbox"/> Brand substitution not permitted			Frequency
	Print Prescriber Name	Prescriber No.	Prescriber Signature	Contact
	Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation		Quantity	Repeats

PHARMACY PRESCRIPTION DUPLICATE			
Discharge Required	Yes / No	Duration/Quantity	Dr. Signature