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Hospital name.....

Hospital Provider number.....

Ward.....

Medication chart number.....of .....

Additional charts

☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other

☐ Palliative care ☐ Chemotherapy ☐ IV heparin

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months

Initials:

Authority Prescription Number

Once only and nurse initiated medicines and pre-medications/Telephone orders

Date/time prescribed	Medicine (print generic name)/form	Route	**Dose**	Frequency	Check initials		Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration				Pharmacy
					N1	N2				Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	

Document admission medications on Medication Management Plan HRxxx

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

PBS Hospital Medication Chart (Long stay) © Commonwealth of Australia 2016 – As amended 2019 (Version 1.1)

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** M ☐ F ☐

Medicare No: **PBS/RPBS Entitlement No.**

☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

First prescriber to print patient name and check label correct:

.....

Approved pharmacy details:

.....

Pharmacy approval no:

.....

Attach ADR sticker

See front page for details

As required PRN medicines

Brand substitution not permitted ☐ **PBS/RPBS** **Year**

Start Date ..... /	Medicine (print generic name)/form		Date														Continue on discharge? Y / N Dispense? Y / N Duration:.....days Qty:..... Prescriber's signature: Date:.....
Route	Dose *and* hourly frequency	**PRN**	Time														
Indication		Max PRN dose/24hr	Dose														
SAC/AAN		Pharmacy	Route														
Prescriber signature			Sign														
Start Date ..... /	Medicine (print generic name)/form		Date														Continue on discharge? Y / N Dispense? Y / N Duration:.....days Qty:..... Prescriber's signature: Date:.....
Route	Dose *and* hourly frequency	**PRN**	Time														
Indication		Max PRN dose/24hr	Dose														
SAC/AAN		Pharmacy	Route														
Prescriber signature			Sign														
Start Date ..... /	Medicine (print generic name)/form		Date														Continue on discharge? Y / N Dispense? Y / N Duration:.....days Qty:..... Prescriber's signature: Date:.....
Route	Dose *and* hourly frequency	**PRN**	Time														
Indication		Max PRN dose/24hr	Dose														
SAC/AAN		Pharmacy	Route														
Prescriber signature			Sign														
Start Date ..... /	Medicine (print generic name)/form		Date														Continue on discharge? Y / N Dispense? Y / N Duration:.....days Qty:..... Prescriber's signature: Date:.....
Route	Dose *and* hourly frequency	**PRN**	Time														
Indication		Max PRN dose/24hr	Dose														
SAC/AAN		Pharmacy	Route														
Prescriber signature			Sign														
Start Date ..... /	Medicine (print generic name)/form		Date														Continue on discharge? Y / N Dispense? Y / N Duration:.....days Qty:..... Prescriber's signature: Date:.....
Route	Dose *and* hourly frequency	**PRN**	Time														
Indication		Max PRN dose/24hr	Dose														
SAC/AAN		Pharmacy	Route														
Prescriber signature			Sign														
		Pharmaceutical review:															

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

Attach ADR sticker

Allergies and adverse drug reactions (ADR)

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

Medicine (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 ☐
Medicare No: **PBS/RPBS Entitlement No.**
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

First prescriber to print patient name and check label correct:

.....

Weight (kg): ..... Height (cm): .....

Cut off section

Regular Medicines

Brand substitution not permitted ☐ **PBS/RPBS** **Year**

Date and month →

Start Date ..... /	Warfarin	Marevan / Coumadin Circle brand
Route	Prescriber to enter individual doses	Target INR Range
Indication	Pharmacy	
Prescriber signature		

INR Result																															
Dose	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg
Prescriber																															
Initial 1 18:00																															
Initial 2																															

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Prescriber to enter administration times →

Start Date ..... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Start Date ..... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Start Date ..... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Start Date ..... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Start Date ..... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:.....
Prescriber's signature:
Date:

Pharmaceutical review:

Check if patient has another medication chart

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.

Anticoagulant education record

Medicine: .....

Education

Provided ☐ Declined ☐
Not appropriate ☐

Written information

Provided ☐ Declined ☐

Written information provided:
CMI ☐ Other: ☐ .....

Signature: .....

Designation:..... Date: .....

Reason for not administering

Codes MUST be circled

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

SAC: Streamline Authority Code
AAN: Authority Approval Number

DO NOT WRITE IN THIS BINDING MARGIN

Cut off section

Check if patient has another medication chart