Medication chart page 1 of 4

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):.....

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 .....

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

Additional charts

☐ IV fluid ☐ Palliative care ☐ BGL/insulin ☐ Chemotherapy ☐ Acute pain ☐ IV heparin ☐ Other

Facility/service:..... Ward/unit:.....

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (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	Medicine (print generic name)	Route	**Dose**	Frequency	Check initials N1	Check initials N2	Prescriber name	Pres. 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 medicines brought in? ☐ Y ☐ N Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

DO NOT WRITE IN THIS BINDING MARGIN

NIMC (GP e-version)

© Commonwealth of Australia 2005 – As amended 2019

Medication chart page 2 of 4

Allergies and adverse drug reactions
See page 1 for details

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:

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 not administering
Codes MUST be circled

(A) Absent	(L) On leave
(F) Fasting	(N) Not available – obtain supply or contact prescriber
(R) Refused – notify prescriber	(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

Anticoagulant education record
Medicine:
Education
Provided ☐ Declined ☐ Not appropriate ☐
Written information
Provided ☐ Declined ☐
Written information provided:
CMI ☐ Other ☐
Signature:
Designation: Date:

Regular medicines

Year 20 Date and month →

Variable dose medicine

Date | Medicine (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 Qty:
Duration: days

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

VTE prophylaxis

Date | Medicine (print generic name)
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

Mechanical prophylaxis — AM check
Prescriber/NI signature | Print your name | Contact — PM check

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

Warfarin

Date | **Warfarin** | **Marevan / Coumadin** select brand
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
Prescriber
1600 Initial 1
Initial 2

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

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Pharmacist: Date:
Pharmacist: Date:
Prescriber's signature: Print your name:

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Medication chart Page 3 of 4

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

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:

Regular medicines

Year 20 **Date and month** →

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Pharmaceutical review:

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

Medication chart

Allergies and adverse drug reactions

See page 2 for details

As required PRN medicines

Year: 20.........

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: ....

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

Date	Medicine (print generic name)			Date
Route	Dose / Hourly frequency / **PRN**		Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose / Route
Prescriber signature	Print your name		Contact	Sign

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

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

DO NOT WRITE IN THIS BINDING MARGIN