REMOVED AREA

REMOVED AREA

Facility/service: .....

Ward/unit: .....

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

Additional charts

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

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 / 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

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Check if patient has another medication chart

NIMC (long-stay)

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	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Date: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

Date	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Pharmacist: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

Date	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Date: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

Date	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Date: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

Date	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Print your name: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

Date	Medicine (print generic name)			Date																Continue on discharge? Yes / No	Dispense? Yes / No	Duration: ..... days Qty:	Prescriber's signature: .....
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time																			
Indication	Pharmacy			Dose																			
				Route																			
Prescriber signature	Print your name	Contact		Sign																			

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**

First prescriber to print patient name and check label correct: ....

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

REMOVED AREA

Regular medicines

Year: 20 .... **Date and month** →

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

Prescriber

1600 Initial 1

Initial 2

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

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
Duration: .... days Qty: ....

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
Duration: .... days Qty: ....

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
Duration: .... days Qty: ....

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
Duration: .... days Qty: ....

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
Duration: .... days Qty: ....

Pharmaceutical review:

Date:

Pharmacist:

Date:

Print your name:

Prescriber's signature:

Anticoagulant education record

Medicine: ....

Education

Provided ☐ Declined ☐

Not appropriate ☐

Written information

Provided ☐ Declined ☐

Written information provided:

CMI ☐ Other: ☐ ....

Signature: ....

Designation: .... 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 not administering
Codes MUST be circled

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

REMOVED AREA

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Check if patient has another medication chart

Check if patient has another medication chart