REMOVED AREA

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	Facility/s Ward/uni		Medication chart number of Additional charts IV fluid BGL/insulin Acute pain Palliative care Chemotherapy IV heparin												
		only a													
Date	Medicine)		Route			Date/time	e of	Prescr	iber / Nu	ırse Initi	ator (NI)	Givon by	Time	Pharmacy
prescribed	d (print generic	name)					dose		Signature	•	Print y	our name		given	
		Tele	phon	e orc	lers	•	e signed	wit	nin 24 h	ours of	order)		ecord of a	dministra	tion
Date time	Medicine (print generic name)	Route	Dose	Frequ	ency	Checl N1	k initials N2	4	escriber name	Pres. sign	Date	Time / given by	Time /	Time /	Time /
	,					141	142					given by	given by	given by	y given by
/ledici	nes taken prior to	presen	tatio	n to l	hos	pital	brought	::-0] N. A.	desisiat	ration sig	l (anasif t)		
Prescrib	Medicine	Dose and			Durat	$\overline{}$	brougin		Medicin		ummst	_	I (specify) and freque		Duration
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	M017	160	11			\top									
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Sign:				Print:			Date						Iministere		

Affix patient identification labe	el here
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Date of birth:	Sex: □M □F
Address:	identifiers present
Given names:	prescription unless
Family name:	Not a valid
URN:	

Attach ADR sticker

See front page for details

As required PRN medications

Year: 20

and chec	k label correct:									 						
Date	Medicine (print gener	ic name)			Date									Yes / No Yes / No ty:		
Route	Dose Hourly freque	ncy PRN	Max PRN o	dose/24 hrs	Time										charge? Yes Yes days Oty	
Indication			Dose										disch d			
Prescriber	Route Sign						+	+			Continue on discharge? Dispense? Duration:days Qt	Date:				
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Indication	ndication Pharmacy														on disc ??	
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Route	Dose Hourly freque	Time														
Indication		Dose							+			ischa .da				
	cation Pharmacy scriber signature Print your name Contact											\perp			e on c se? n:	
Prescriber		Sign										Yes / No Continue on discharge? Yes / No Dispense? /	Date:			
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Indication	Dose										discha di					
Prescriber signature Print your name Contact														_	Continue on discharge? Yes / No Dispense? Yes / No Duration: days Qty:	
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			Max PRN o	J/04 h	Date									_	Yes / No Yes / No by:	
Route	Dose Hourly freque	ncy PRN	Max PRIN C	10Se/24 FIRS	Time										Continue on discharge? Yes Dispense? Yes Duration:days Qty:	Print your name:
Indication	-	Pharmacy			Dose										n disc	l ii
Prescriber :	signature Print yo	ur name		Contact	Route							+		-	Continue or Dispense? Duration:	nt yo
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Prescriber	aignature Pfifft yo	ur name		Contact	Sign										ontinue or ispense? uration:	res

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

Atta	ch ADR sticker		URN:	
	dverse drug reactions wn (tick appropriate box or complete d		Family name:	Not a valid
Medicine (or other)	Reaction / type / date	Initials	Given names:	prescription unless
			Address:	identifiers present
			Date of birth:	Sex: □ M □ F
			First prescriber to print pa and check label correct:	atient name Weight (kg):Height (cm):
Sian	Print Date	2		5 . 5.

DO NOT WRITE IN THIS BINDING MARGIN

REMOVED AREA

Sign	Print	Date												X	X																	
Regula	r medicines																															
Year: 20		Date and month																													Anticoagulant educatio	on record
Date	Warfarin	(Marevan / Coumadin) select brand	INR result											П																	Education Provided Declined	
Route	Prescriber to enter individual doses	Target INR range	Dose	mg	mg r	mg mg	mg	mg i	mg mg	g mg	mg m	g mg	mg mg	ma	ma m	ng mg	ma	mg mg	mg	mg mg	g mg	ma ma	mg m	g mg	mg m	g mg	mg	mg mg	Yes / No Yes / No	Date:	Not appropriate Written information	
Indication		Pharmacy	Prescriber					J																					tharge? days Qty	اق	Provided Declined Written information provided	
Prescriber sig	nature Print you	r name Contact	1600 Initial 1																									:	iue on disc nse? on:		CMI Other:	
PRESCRIB	ER MUST ENTER ad	ministration times	Initial 2																										Continu Dispena Duratio		Designation:) Date:
Date	Medicine (print generic nam	Tick if slow release												П															Yes / No Yes / No			
Route	Dose Frequency and N																												ge? Yes Yes s Qty:	acist:	Recommende administration til	imes
Indication	Pharm	nacy																											n dischar	Pharmacist:	Morning Mane 0800	
Prescriber sig	nature Print your nan	ne Contact	-																									-	Continue on Dispense? Duration:		Night Nocte Twice a day BD 0800	1800 or 2000 2000
Date	Medicine (print generic nam	slow																											fes / No Cc fes / No Di		Three times a day TDS 0800 1400	+
Route [Dose Frequency and N	OW enter times	<u> </u> 																										Je? Yes Yes Otty:	ë	Regular 6 hrly 0600 1200 Regular 8 hrly 0600 1400 1400	
Indication	Pharm	nacy								H																		_	discharg		Four times a day QID 0600 1200	1800 2200
Prescriber sig	nature Print your nan	ne Contact								П																			Continue on Dispense? Duration:			
Date	Medicine (print generic nam			H					+	\vdash				Н																	SR = Sustained, n or controlled relea formulation.	
Route	Dose Frequency and N	Slow release OW enter times																											? Yes / No Yes / No Oty:		Tick if slow release If scored tablet, the be given.	nen half can
Indication	Pharm	nacy	1							\vdash																		_	ischarge days		Dose must be swa without crushing.	
Prescriber sig	nature Print your nan	ne Contact	-																										ontinue on d ispense? uration:	name:		
	Medicine (print generic nam																												$\circ \circ \circ$	t your	Reason for not administeri	ing
	Dose Frequency and N	slow release	<u> </u>							\vdash																			Yes / No Yes / No /:	Prin	Codes MUST be circle Absent	A
										П																			harge? days Ott			
Indication	Pharm																												on disc		Fasting	(F)
Prescriber sig	nature Print your nan	ne Contact								\vdash																			Continue on Dispense? Duration:		Refused – notify prescriber	
Date	Medicine (print generic nam	Tick if slow release																													Vomiting	V
Route	Dose Frequency and N	OW enter times																											s / No	 	On leave	L
Indication	Pharm	nacy		П																									rge? Yes/ Yes/		Not available – obtain supp or contact prescriber	ply N
Prescriber sig	nature Print your nan	ne Contact																											on dischar?	er's	Withheld – enter reason in clinical record	W
		Diameter 1																											inue o ense? ttion:	scrib	Self administered	(S)