

Affix patient identification label here

**URN:**  
**Family name:** Not a valid  
**Given names:** prescription unless  
**Address:** 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 medicines

Year: 20.....

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

DO NOT WRITE IN THIS BINDING MARGIN

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Date: Pharmacist:    Print your name:    Date:    Pharmacist:

## Cut off section

**Medication chart number** ..... **of** .....  
 Facility/service: .....  
 Ward/unit: .....  
 Additional charts:  
 IV fluid     BGL/insulin     Acute pain     Other  
 Palliative care     Chemotherapy     IV heparin

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		Prescriber name	Pres. sign	Date	Record of administration									
					N1	N2				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 <input type="checkbox"/> N <input type="checkbox"/> Administration aid (specify) .....					
Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

**GP:** .....                      **Community pharmacy:** .....  
**Sign:** .....                      **Print:** .....                      **Date:** .....                      **Medicines usually administered by:** .....

NIMC (acute)

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Cut off section

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Affix patient identification label here and overleaf

Allergies and adverse drug reactions (ADR) table with columns for Medicine (or other), Reaction / type / date, and Initials.

Patient information form including URN, Family name, Given names, Address, Date of birth, Sex (M/F), Weight (kg), and Height (cm).

First prescriber to print patient name and check label correct:

Regular medicines

Large grid for recording regular medicines with columns for Date, Medicine, Dose, Frequency, and Pharmacy. Includes sections for VTE risk, VTE prophylaxis, Warfarin, and a 'PRESCRIBER MUST ENTER administration times' section.

Recommended administration times

Table showing recommended administration times for various frequencies: Morning, Night, Twice a day, Three times a day, Regular 6 hourly, Regular 8 hourly, Four times a day.

Anticoagulant education record form with sections for Education (Provided/Declined/Not appropriate) and Written information (Provided/Declined).

Reason for not administering form with codes A (Absent), F (Fasting), R (Refused - notify prescriber), V (Vomiting), L (On leave), N (Not available - obtain supply or contact prescriber), W (Withheld - enter reason in clinical record), and S (Self administered).

Regular medicines

Large grid for recording regular medicines, similar to the left page but with a 'PRESCRIBER MUST ENTER administration times' section at the top.

