34mm

URN:	Not a valid prescription unless identifiers present
Family name:	
Given names:	
Address:	
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

100mm

26mm 75mm

Approved pharmacy details: ....

Pharmacy approval no: ....

45mm 8mm

Attach ADR sticker

See front page for details

8mm **First prescriber to print patient name and check label correct:**

....

72mm 175mm

226mm

As required PRN medicines

Brand substitution not permitted ☐ **PBS/PRBS** **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	
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

Cut off section

PRINT DIGI CMYK 2/S ON 220gsm UNCOATED.
PRODUCE DIGITAL PROOFS FROM FILES SUPPLIED.
DIE-CUT AND STRIP 1 RECTANGULAR PIECE FROM TOP RHC.
CREASE. TRIM TO 297 x 420mm. FOLD TO 297 x 210mm.
DRILL 2 x HOLES FOR RING BINDER. BULK PACK

DO NOT WRITE IN THIS BINDING MARGIN

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

26mm

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

91mm

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

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

60mm

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: ....

48mm

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

180mm 10mm 9.5mm

Check if patient has another medication chart

PBS Hospital Medication Chart A (Acute)

Cut off section

PRINT DIGI CMYK 2/S ON 220gsm UNCOATED.
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DRILL 2 x HOLES FOR RING BINDER. BULK PACK

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): ....

Regular Medicines

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

Variable dose medicine — **Date and month**

Start Date ...... /	Medicine (print generic name)/form
Route	Frequency — Prescriber to enter dose times and individual dose
Indication	Pharmacy
Prescriber signature	SAC/AAN

Drug level / Time level taken / **Dose** / Prescriber / Time to be given / Nurse initial

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

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

Start Date ...... /	Medicine (print generic name)/form
Route	*Dose and Frequency* — and now enter times →
Indication **VTE prophylaxis**	Pharmacy
Prescriber	SAC/AAN
Mechanical prophylaxis	
Signature / NI signature	Print name

AM check / **PM check**

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

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) / 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: ......

Pharmaceutical review:

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

Regular Medicines

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

Date and month
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: ......

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

Check if patient has another medication chart