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

First prescriber to print patient name and check label correct:

Approved pharmacy details: ....

Pharmacy approval no: ....

Attach ADR sticker

See front page for details

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

As required PRN medicines

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign

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

Start Date ...... /	Medicine (print generic name)/form	Date
Route	Dose *and* hourly frequency PRN	Time
Indication	Max PRN dose/24hr	Dose
SAC/AAN	Pharmacy	Route
Prescriber signature		Sign
Pharmaceutical review:		

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

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

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

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

Document admission medications on Medication Management Plan HRxxx

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

Check if patient has another medication chart

PBS Hospital Medication Chart B (Acute)

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

4mm 45mm

Attach ADR sticker

5mm

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 ....

2.5mm 4mm

53mm

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): ....

100mm

47mm

Regular Medicines

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

Variable dose medicine **Date and month** →

Start Date ...... /	Medicine (print generic name)/form	Drug level Time level taken
Route	Frequency Prescriber to enter dose times and individual dose	**Dose**
Indication	Pharmacy	Prescriber Time to be given
Prescriber signature	SAC/AAN	Nurse initial

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

57mm

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		AM check
Signature / NI signature	Print name	PM check

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

36mm

Start Date ...... /	Warfarin	**Marevan / Coumadin** Circle brand	INR Result
Route	Prescriber to enter individual doses	Target INR Range	Dose mg mg mg mg mg mg mg mg mg mg
Indication	Pharmacy		Prescriber
Prescriber signature			Initial 1 18:00 Initial 2

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

79mm

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:

175mm

Check if patient has another medication chart

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

44mm

27mm

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: ....

43mm 42.5mm 223mm

77mm

Reason for not administering

Codes MUST be circled

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

SAC: Streamline Authority Code
AAN: Authority Approval Number

11mm

10mm

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:

10mm

Check if patient has another medication chart