REMOVED AREA

SECTION A

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): .....

Date weighed: .....

Height (cm): ..... BSA (m^2): .....

Gestational age at birth (wks): .....

Paediatric NIMC (paediatric) private hospital Paediatric

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 medicines

Weight (kg): .....

Date weighed: .....

Ward/unit: .....

Not a valid order unless legible

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

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

REMOVED AREA

SECTION A

Ward/unit: .....

Paediatric Medication chart number ___ of ___

Additional charts

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

Once only medicines

Date prescribed	Medicine (print generic name)	Route	**Dose**	Dose calc eg. mg/kg per dose	Date/time to be given	Prescriber: Signature	Prescriber: Print your name	Given by	Date/time given	Pharm

Telephone orders (to be signed within 24 hours of order)

Date time	Medicine (print generic name)	Route	**Dose**	Dose calc eg. mg/kg per 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

Medicines taken prior to presentation to hospital

(prescribed, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N

Medicine and formulation	Dose and frequency	Duration	Medicine and formulation	Dose and frequency	Duration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

REMOVED AREA

SECTION B

Regular medicines

Not a valid order unless legible

Year 20..... Date and month →

PRESCRIBER MUST ENTER administration times →

Date	Patient name 1st 2nd	☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route
Dose	Frequency and NOW enter times →	
Indication	Pharmacy	**Dose** calculation (eg. mg/kg per dose)
Prescriber name	Prescriber No	Prescriber signature
Contact	Quantity	Repeats

Prescriber: please press firmly – pharmacy prescriptions underneath

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

Date:

Pharmacist:

Pager:

Print your name:

Prescriber's signature:

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.

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
Parent/carer administered	P

Regular medicines

Year 20..... Date and month →

PRESCRIBER MUST ENTER administration times →

Date	Patient name 1st 2nd	☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route
Dose	Frequency and NOW enter times →	
Indication	Pharmacy	**Dose** calculation (eg. mg/kg per dose)
Prescriber name	Prescriber No	Prescriber signature
Contact	Quantity	Repeats

Prescriber: please press firmly – pharmacy prescriptions underneath

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

Date:

Pharmacist:

Pager:

Print your name:

Prescriber's signature:

Pharmaceutical review:

REMOVED AREA

SECTION C

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

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Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Medicare Australia/DVA copy – valid for use as PBS at: | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

REMOVED AREA

SECTION D

Pharmacy prescription

Date
Patient name 1st 2nd
☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted
Indication
Pharmacist/patient copy – valid for use with PBS repeat authorisation
Dose calculation (eg. mg/kg per dose)
Prescriber name
Prescriber No
Prescriber signature
Contact
Quantity
Repeats

Pharmacy prescription

Date
Patient name 1st 2nd
☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted
Indication
Pharmacist/patient copy – valid for use with PBS repeat authorisation
Dose calculation (eg. mg/kg per dose)
Prescriber name
Prescriber No
Prescriber signature
Contact
Quantity
Repeats

Pharmacy prescription

Pharmacy prescription

Pharmacy prescription

Date
Patient name 1st 2nd
☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted
Indication
Pharmacist/patient copy – valid for use with PBS repeat authorisation
Dose calculation (eg. mg/kg per dose)
Prescriber name
Prescriber No
Prescriber signature
Contact
Quantity
Repeats

Pharmacy prescription

Date
Patient name 1st 2nd
☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted
Indication
Pharmacist/patient copy – valid for use with PBS repeat authorisation
Dose calculation (eg. mg/kg per dose)
Prescriber name
Prescriber No
Prescriber signature
Contact
Quantity
Repeats

Pharmacy prescription

Pharmacy prescription

Pharmacy prescription

Date
Patient name 1st 2nd
☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name)
Tick if slow release
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Medicine (print generic name)
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Frequency and NOW enter times →
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Indication
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Dose calculation (eg. mg/kg per dose)
Prescriber name
Prescriber No
Prescriber signature
Contact
Quantity
Repeats

Pharmacy prescription

Pharmacy prescription