COMMONWEALTH OF AUSTRALIA

DEPARTMENT OF HEALTH

National Health Act 1953
National Health (Pharmaceutical Benefits) Regulations 2017

INSTRUMENT OF APPROVAL FOR PBS HOSPITAL MEDICATION CHARTS

I, Thea Daniel, Assistant Secretary, Pricing and PBS Policy Branch, Technology Assessment and Access Division, Department of Health have the authority to approve forms of medication charts for the prescribing, supply and claiming of PBS medicines, under subsection 41(5) of the *National Health (Pharmaceutical Benefits) Regulations 2017* (the Regulations), as Delegate for the Secretary of the Department of Health.

A medication chart is a chart in a form approved under subsection 41(5) of the Regulations, used for prescribing, and recording the administration of pharmaceutical benefits to persons receiving treatment in or at a residential care service or hospital, whether or not the chart is used for any other purpose, or contains any other information. An electronic medication chart is a medication chart in a form approved under subsection 41(5) of the Regulations for the purpose of writing an electronic prescription.

I hereby revoke the instrument of approval as signed by the Assistant Secretary, Pharmaceutical Benefits Division, Department of Health on 27 April 2017, approving five medication charts for use in Australian hospitals. In its place, I approve the following:

(a) for the purposes of a chart that is used for prescribing, and recording the administration of, pharmaceutical benefits to persons receiving treatment in a hospital—a form attached to this instrument (which include):

- PBS Hospital Medication Chart A (Acute)
- PBS Hospital Medication Chart B (Acute)
- PBS Hospital Medication Chart (Long Stay)
- Peter MacCallum Cancer Centre Chart
- Western Australian PBS Medication Chart (Acute) – use restricted to Western Australian Hospitals only.

(b) for the purposes of writing an electronic prescription—an electronic form that includes all of the information specified in a form that attached to this instrument.

This instrument commences on 1 November 2019.

Dated this 30th day of October 2019

Thea Daniel
Assistant Secretary
Pricing and PBS Policy Branch
Technology Assessment and Access Division
Department of Health

Cut off section

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		Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration				Pharmacy
					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 ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

GP:

Community pharmacy:

Sign: ..... Print: ..... Date: ..... Medicines usually administered by: .....

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:						
Date:						

Check if patient has another medication chart

30/10

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart A (Acute)

Cut off section

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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
Prescriber's signature:.....
Date:.....

Pharmaceutical review:

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Morning	Mane	08(
Night	Nocte	
Twice a day	BD	08(
Three times a day	TDS	080
Regular 6 hourly	6 hrly	06(
Regular 8 hourly	8 hrly	06(
Four times a day	QID	060

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Written informatio
Provided ☐ Decl
Written information
CMI ☐ Other: ☐
Signature:.....
Designation:.....

Reason
admini
Codes MUS

Absent
Fasting
On leave
Not available – ol
supply or contact
Refused – notify
Self administered
Vomiting
Withheld – enter
clinical record

SAC: Streamline
AAN: Authority A

Check if patient has another medication chart

20/10

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

Approved pharmacy details:

Pharmacy approval no:

First prescriber to print patient name and check label correct:

Attach ADR sticker

See front page for details

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: ....

DO NOT WRITE IN THIS BINDING MARGIN

30/10

Check if patient has another medication chart

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): ....

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	2000	
1400	2000	
1200	1800	2400
1400	2200	
1200	1800	2200

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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

30/10

Cut off section

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		Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration				Pharmacy
					N1	N2				Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	

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:						
Date:						

Check if patient has another medication chart

30/10

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart B (Acute)

Cut off section

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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
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 Qty:.....
Duration:.....days
Prescriber's signature:.....
Date:.....

Pharmaceutical review:

Recomm administra Guidelin		
Morning	Mane	080
Night	Nocte	
Twice a day	BD	080
Three times a day	TDS	080
Regular 6 hourly	6 hrly	060
Regular 8 hourly	8 hrly	060
Four times a day	QID	060

SR = Sus or contro formulati

Tick if slow release

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Dose mu without c

Anticoagulant e
Medicine: .....
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Provided ☐ Dec
Not appropriate ☐
Written informatic
Provided ☐ Dec
Written information
CMI ☐ Other: ☐
Signature: .....
Designation: .....

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Codes MU

Absent
Fasting
On leave
Not available – o supply or contac
Refused – notify
Self administere
Vomiting
Withheld – enter clinical record

SAC: Streamline
AAN: Authority A

30/10

Check if patient has another medication chart

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

Approved pharmacy details:

Pharmacy approval no:

Attach ADR sticker

See front page for details

First prescriber to print patient name and check label correct:

As required PRN medicines

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

DO NOT WRITE IN THIS BINDING MARGIN

30/10

Check if patient has another medication chart

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): ....

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only

	1800 or 2000	
	2000	
1400	2000	
1200	1800	2400
1400	2200	
1200	1800	2200

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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

30/10

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

Approved pharmacy details:

Pharmacy approval no:

Attach ADR sticker
See front page for details

First prescriber to print patient name and check label correct:

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

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

Pharmaceutical review:

DO NOT WRITE IN THIS BINDING MARGIN

Check if patient has another medication chart

30/10

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): ....

DO NOT WRITE IN THIS BINDING MARGIN

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year

			Date and month →
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 mg mg)
Indication	Pharmacy		Prescriber
Prescriber signature			Initial 1 18:00
			Initial 2

Prescriber to enter administration times

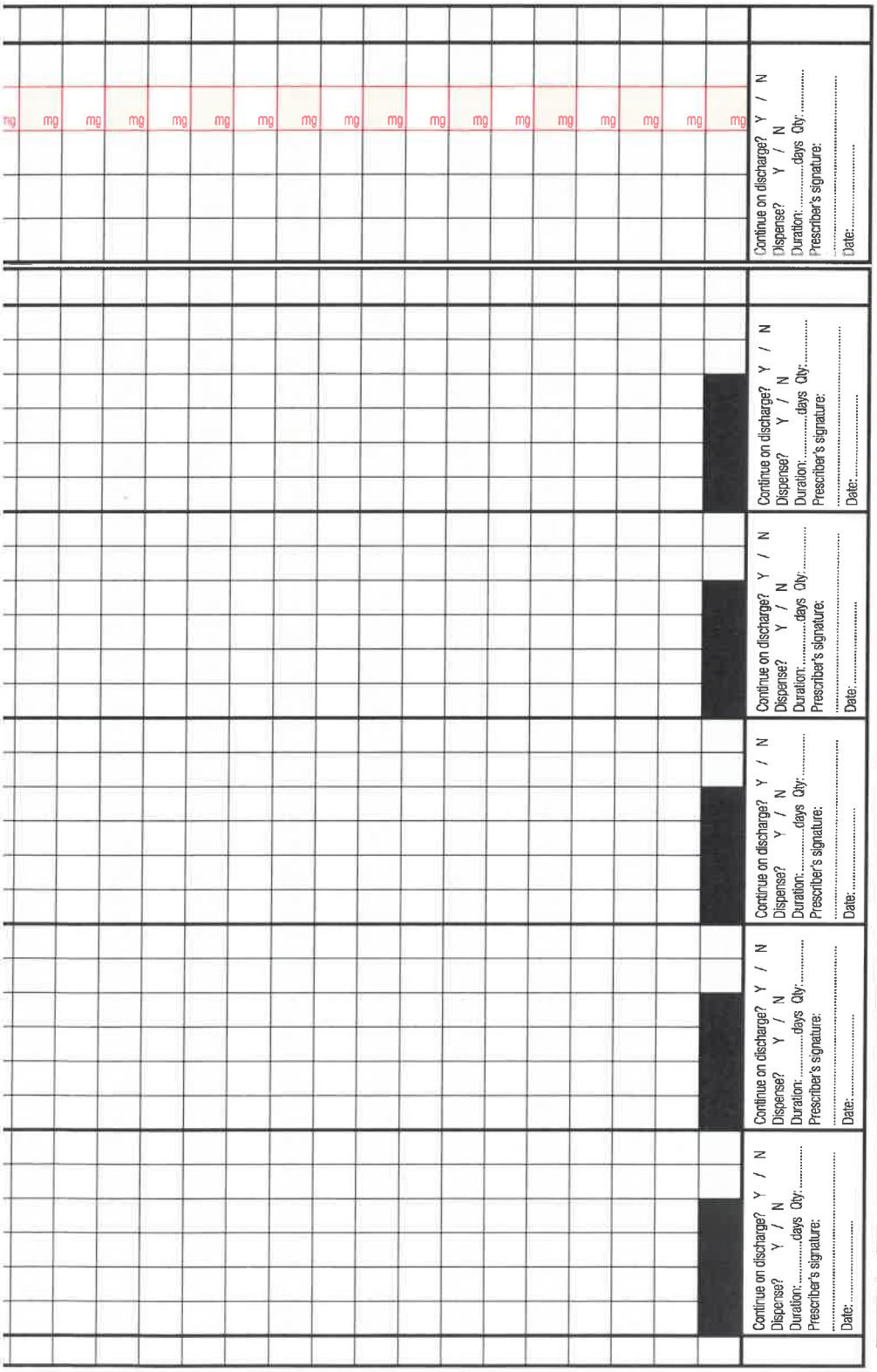
Start Date ...... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	
Start Date ...... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency	and now enter times →
Indication	Pharmacy	
Prescriber signature	SAC/AAN	
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	
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	
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	

Pharmaceutical review:

Check if patient has another medication chart

30/10

Cut off section



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

Check if patient has another medication chart

30/10

Cut off section

Cut off section

Cut off section

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

PBS Hospital Medication Chart (Long Stay)

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:						
Date:						

Check if patient has another medication chart

30/10

CUT OUT

Peter MacCallum Cancer Centre

Hospital Provider Number: HV086Y

Medication Chart No. ☐ of ☐

Ward: .....

Chart Valid for: 1 month ☑ 4 months ☐ 12 months ☐

Authority prescription applications 24 hour service
PBS 1800 888 333 RPBS 1800 552 580

Authority Prescription Number

Prescriber details				
	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4
Name				
Prescriber No.				
Contact No.				
Address	305 Grattan Street, Melbourne 3000			
Signature: Date:	Signature: Date:	Signature: Date:	Signature: Date:	Signature: Date:

USING THE PBS HOSPITAL MEDICATION CHART FOR DISCHARGE

1. **FOR DISCHARGE?**: Specify whether each medication is to continue on discharge by ticking Y or N in the discharge section.
2. **CHECK THE MEDICATION ORDER**: Check the appropriateness of each medication, route, dose, and frequency for discharge.
3. **QUANTITY***: Write the quantity for each medication (words and figures for S8 medications) in the discharge section.
4. **APPROVAL No***: Write PBS Approval Numbers or PBS Streamline Authority Codes when appropriate in the discharge section. Please note the Authority Prescription Number for each chart is different and must correspond to each medications approval or streamline authority number.
5. **SIGN**: Sign each medication order and complete the **PRESCRIBER DETAILS** section at the front of each chart.
6. **COMPLEX DIRECTIONS**: If any medication orders have complicated directions for discharge (e.g. steroid reducing dose) use the complex directions section.
7. **NOTIFY THE PHARMACIST**: Ensure your ward pharmacist is aware when all of the above is complete.
8. **SUPPLY?**: The pharmacist will indicate whether a supply is required or not.

THE PBS HOSPITAL MEDICATION CHART CANNOT BE USED FOR:

- **REPEATS**
- **DEFERRALS**
- **REGULATION 24**
- **A SUPPLY FROM ANOTHER PHARMACY**: only Peter MacCallum Pharmacy can dispense and claim PBS items from the PBS hospital medication charts.

A hospital prescription must be completed for supply to be provided if the PBS chart cannot be used.

*See www.pbs.gov.au or PBS mobile application for more information

Medication taken prior to presentation to hospital (Refer to pharmacists medication reconciliation form for a full medication history).

(Prescribed, over the counter, complementary) Own medication brought in ? Y☐ N☐ Administration aid (specify) .....

Medication	Dose and frequency	Duration	Medication	Dose and frequency	Duration

GP:

Community pharmacy:

Sign: Print: Date: Medicines usually administered by

INPATIENT MEDICATION CHART MR/61

09/16

30/10

CUT OUT

Affix patient ID label

ONCE ONLY, PRE-MEDICATION, TELEPHONE ORDERS & NURSE INITIATED MEDICATION

(Telephone orders MUST be signed within 24 hrs of order)

Date Prescribed	Medicine (print generic name) / form	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Prescriber/Nurse Initiator (NI) Print Name	Given by	Time Given	Pharmacy

COMPLEX DIRECTIONS FOR DISCHARGE (Please ensure there is a medication order written in the regular or when required medication section in addition to the directions below and the discharge section has been completed)

Medication (print generic name) and form	Strength	Directions (must include dose, route, frequency and duration)
PM 30/10		

RECOMM ADMINISTRA GUIDELIN

Morning	Mane	
Night	Nocte	
Twice a day	BD	
Three times a day	TDS	
Regular 2 hourly	2 hrly	
Regular 3 hourly	3 hrly	
Four times a day	QID	

SR = Sus modified release

Tick if Slow Release

If scored half can

Dose mu without c

WARFARIN E RECO

Patient Educate

Sign:

Date:

Given Warfarin

Sign:

Date:

REASO NOT ADMIN

Codes MUS

Absent

Fasting

On leave

Not available – ob supply or contact

Refused – notify

Self administered

Vomiting

Withheld – enter r in clinical record

SAC: Streamline

AAN: Authority Ap

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 ____________

URN:
Family name:
Given names:
Address:

Date of birth: Sex: M☐ F☐

☐ Concessional or dependent RPBS or Safety Net Concession Card Holder
☐ Safety Net Entitlement Card Holder

Weight (kg)____________ Height (cm)____________

First prescriber to print patient name and check label correct:

REGULAR MEDICATION

YEAR: 20______ DATE AND MONTH →

Discharge Section

VARIABLE DOSE MEDICATION

Start Date	Medicine (print generic name) / form			Drug level
				Time level taken
Route	Frequency Prescriber to enter dose times and individual dose			Dose
				Prescriber
Indication	Pharmacy			Time to be given:
Prescriber signature	Print Name	Contact		Nurse

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
SAC/AAN
....
Prescriber Signature
....
Date ....

VTE RISK PROFILE ASSESSED? ☐

P-TP = PHARMACOLOGICAL THROMBOPROPHYLAXIS

Surgical Patients Follow STEP		NOTE	Medical Patients	
	Low ☐ → Mobilise Early (no TEDS) + inpt P-TP Intermediate ☐ → TEDS ≥7 days + inpt P-TP High ☐ → P-TP ≥7 days + inpt TEDs Major Abdominopelvic ☐ → P-TP ≥ 28 days + inpt TEDs	• Use TEDS if P-TP contraindicated • P-TP intraop or within 6 hr postop • See STEP protocol for full details		All medical inpatients at Peter MacCallum should receive P-TP as an inpatient unless contraindications exist.

Start Date	Medicine (print generic name) / form		
Route	Dose	Frequency and write time(s) →	
Indication: Pharmacological Thromboprophylaxis WITHOLD if platelets below		Pharmacy	
Prescriber signature	Print name	Contact	

If NO P-TP prescribed state reason
☐ On anticoagulant ☐ Other ....
☐ Contraindicated

Review Date

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Mechanical Prophylaxis			AM check
Prescriber/NI signature	Print name	Contact	PM check

For Discharge? Y ☐ N ☐
Prescriber Signature
....

Start Date	Medicine (print generic name) / form		Tick if Slow Release	6
				8
Route	Dose	Frequency and select time(s) →		12
				14
Indication	Pharmacy			18
Prescriber signature	Print Name	Contact		20
				22

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form		Tick if Slow Release	6
				8
Route	Dose	Frequency and select time(s) →		12
				14
Indication	Pharmacy			18
Prescriber signature	Print Name	Contact		20
				22

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form		Tick if Slow Release	6
				8
Route	Dose	Frequency and select time(s) →		12
				14
Indication	Pharmacy			18
Prescriber signature	Print Name	Contact		20
				22

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Pharmacist Pager Clinical Pharmacist Review:

30/10

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ON TIMES
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1400 2000
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1400 2200
1200 1800 2200

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hority Code
oval Number

CUT OUT

Affix patient ID label

REGULAR MEDICATION

YEAR: 20____ DATE AND MONTH →	Time								Discharge Section
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....
Start Date / Medicine (print generic name) / form / Tick if Slow Release	6								For Discharge? Y ☐ N ☐
	8								Dispense Y ☐ N ☐
Route / Dose / Frequency and select time(s) →	12								Quantity ....
	14								....
Indication / Pharmacy	18								SAC/AAN ....
	20								Prescriber Signature ....
Prescriber signature / Print Name / Contact	22								Date ....

Pharmacist Pager	Clinical Pharmacist Review:								

30/10

CUT OUT

Affix patient ID label

AS REQUIRED PRN MEDICINES

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Start Date	Medicine (print generic name) / form			Date
				Time
Route	Dose	Hourly Frequency PRN	Max Dose/24hr	Dose
Indication		Pharmacy		Route
Prescriber signature	Print Name		Contact	Sign

For Discharge? Y ☐ N ☐
Dispense Y ☐ N ☐
Quantity
....
....
SAC/AAN
....
Prescriber Signature
....
Date ....

Pharmacist Pager   Clinical Pharmacist Review:

30/10

CUT OUT

GM
30/10

CUT OUT

30/10

30/10

Cut off section

Hospital name.....

Hospital Provider number.....

Ward.....Team.....

Medication chart number.....**of**.....

Additional charts ☐ Variable dose ☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other ☐ Palliative care ☐ Chemotherapy ☐ IV heparin ☐ Anticoagulation

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months

First prescriber to complete:

Initials:

Authority Prescription Number XXXXXXXX

ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES

Date/time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator Signature	Prescriber/Nurse/Midwife Initiator Print your name	Given by	Time/ Given	Pharmacy

TELEPHONE ORDER (to be signed within 24 hours of order)

Date/ Time	Medicine (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary)

☐ See WA MMP **Own medicines brought in?** Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:						
Date:						

Check if patient has another medication chart

30/10

DO NOT WRITE IN THIS BINDING MARGIN

HCCXXX

XXXX 03/17

PBS Hospital Medication Chart A (Acute)

MR XXX

Cut off section

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS

Year

Variable dose medicine		Date and month →									
Start Date ...... /	Medicine (print generic name)/form	Drug level									Continue on discharge? Y / N Dispense? Y / N Duration: ....days Qty: .... Prescriber's signature: Date:
Route	Frequency Prescriber to enter dose times and individual dose	Time level taken									
		Dose									
Indication	Pharmacy Imprest	Prescriber									
Prescriber signature	Print name SAC/AAN	Time to be given									
		Nurse initial									

Venous Thromboembolism (VTE) risk assessment / Anticoagulation

☐ **VTE risk considered** (refer guidelines) ☐ **Bleeding risk considered**

Pharmacological Prophylaxis: ☐ Indicated* ☐ Not Indicated ☐ Contraindicated

*Consider surgical and anaesthetic implications prior to prescribing

Mechanical Prophylaxis: ☐ GCS ☐ IPC ☐ VFP ☐ Not Indicated ☐ Contraindicated

Key: GCS – Graduated Compression Stockings; IPC – Intermittent Pneumatic Compression; VFP – Venous Foot Pumps

Risk Assessment completed by (name):

Date: Time:

☐ **Warfarin / Anticoagulant in use**

Refer to Anticoagulation Chart for administration details

Additional Charts – Tick if in use

☐ Insulin and BGL Monitoring Chart (☐ Subcutaneous or ☐ Intravenous Infusion)

☐ Intravenous (IV) Fluid ☐ Chemotherapy

☐ Acute Pain ☐ Palliative Care

☐ Clozapine ☐ Other ....

Year 20............ DATE AND MONTH → Doctors MUST ENTER administration times												
Start Date ...... /	Medicine (print generic name)/form Tick if slow release											Continue on discharge? Y / N Dispense? Y / N Duration: ....days Qty: .... Prescriber's signature: Date:
Route	Dose and Frequency and now enter times →											
Indication	Pharmacy Imprest S8 S4R											
Prescriber signature	Print name SAC/AAN											
Start Date ...... /	Medicine (print generic name)/form Tick if slow release											Continue on discharge? Y / N Dispense? Y / N Duration: ....days Qty: .... Prescriber's signature: Date:
Route	Dose and Frequency and now enter times →											
Indication	Pharmacy Imprest S8 S4R											
Prescriber signature	Print name SAC/AAN											
Start Date ...... /	Medicine (print generic name)/form Tick if slow release											Continue on discharge? Y / N Dispense? Y / N Duration: ....days Qty: .... Prescriber's signature: Date:
Route	Dose and Frequency and now enter times →											
Indication	Pharmacy Imprest S8 S4R											
Prescriber signature	Print name SAC/AAN											
Pharmaceutical review:												

Check if patient has another medication chart

Reco adminis Guid

Morning	Mane
Night	Nocte
Twice a day	BD
Three times a day	TDS
Regular 6 hourly	6 hrly
Regular 8 hourly	8 hrly
Four times a day	QID

SR = S or con formul

Tick if slow release

If scor can be

Dose r withou

Warfarin e

Patient educat

Sign:

Date:

Patient supplie

Sign:

Date:

Reas adm

Codes M

Absent

Fasting

On leave

Not available – supply or conta

Refused – notif

Self administer

Vomiting

Withheld – ente clinical record

SAC: Streamlir

AAN: Authority

39/110

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:

Not a valid prescription unless identifiers present

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:

....

Weight (kg): .... Height (cm): .... Date: ....../....../......

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1800 or 2000	
2000	
2000	
1800	2400
2200	
1800	2200

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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 | Impress S8 S4R
Prescriber signature | Print name | 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 | Impress S8 S4R
Prescriber signature | Print name | 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 | Impress S8 S4R
Prescriber signature | Print name | 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 | Impress S8 S4R
Prescriber signature | Print name | 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 | Impress S8 S4R
Prescriber signature | Print name | 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 →
Indication | Pharmacy | Impress S8 S4R
Prescriber signature | Print name | 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

30/10

URN:
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

Not a valid prescription unless identifiers present

Approved pharmacy details: ....

Pharmacy approval no: ....

Attach ADR sticker

See front page for details

First prescriber to print patient name and check label correct

As required PRN medicines

Brand substitution not permitted ☐ PBS/RPBS

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 Imprest S8 S4R	Route										
Prescriber signature		Print Name	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 Imprest S8 S4R	Route										
Prescriber signature		Print Name	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 Imprest S8 S4R	Route										
Prescriber signature		Print Name	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 Imprest S8 S4R	Route										
Prescriber signature Print Name			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 Imprest S8 S4R	Route										
Prescriber signature		Print Name	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 Imprest S8 S4R	Route										
Prescriber signature		Print Name	Sign										
		Pharmaceutical review:											

DO NOT WRITE IN THIS BINDING MARGIN

Check if patient has another medication chart

JM 30/10