	Attach	ADR stick	er			Affix p	patient identification label her	e and overleaf	
Alle	ergies and adve	erse drug rea	ctions (AD	R)	URN:				
🗆 Nil kr	nown Unknown (tic		complete details b		Family na	me:			
Weut		neaction / ty	pe / une	initials	Given nar	nes:			
					Address:				
					Date of bi	rth:		Sex: M	□ F □
					First clin	ician to p	rint patient name and check I	abel correct:	
Sian	Print		Date				-		
		∆: Changed	scribed and <b>X</b> : Cease d dose CMI: CM		Checklist	ional drugs	Inserted/Instilled	Topical Injections Refrigerated items	
: Not char	•						s (HRM) Indling medicine (specify)		
<u> </u>			5 (			storage/na	Inding medicine (specify)		
	b medicines in the pa bbial course ceased	ist 4 weeks	Reason for c	nange				By whom	
Medic	ation History	y and Reco	nciliatior	<b>1</b> 🗌 Nil r	regular medici	nes (confiri	med by		)
	Medicine				Admission Plan (Refer to Legend)			<b>Discharge Plan</b> (Refer to Legend)	
Generic Name/Trade Name, Strength and Form (ie.SR, wafers etc)			Dose, Frequency & Route		Admission Plan Prescribe		Comments/Indication	Plan	Dispense Y/N
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Admission [	Date: / / /	Time: :	Date/	Time Compl	eted: /				
Name:			Pager:		Prescriber	Pharma	acist 🗌 Nurse/Midwife		
		ion Manag	ement Is:	sues			Suspected n	nedicine-related	admission
Identif	ied Medicat	5			Person Responsible		Result of Action		
Identif	ied Medicat		d and Proposed /	Action			Person Responsible	Result of A	Action
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Date/Time	Issue identified by:	Issue Identifie						Result of /	
Date/Time		Issue Identifie							
Date/Time		Issue Identifie	Conta	act number: .			Contacted: Y / N		1
Date/Time	Issue identified by:	Issue Identifie	Conta	act number: .			Contacted: Y / N	Date: /	1

**KEEP WITH ACTIVE MEDICATION CHART – DO NOT REMOVE** 

Contact number:

Date:

Contacted: Y / N

DO NOT WRITE IN THIS BINDING MARGIN

Issue identified by:

Presenting complaint:					URN:		
Past medical history:							
r ast metioar mistory.					Family name:		
Weight (kg):	Date weighed (DD/MM): /	Other:			Given names:		
BSA (m²):	IBW (kg):	Height (cm	):		Address:		
Serum creatinine on admission (micromol/L):	Serum creatinine (micromol/L):	CrCl (mL/n	nin):		Date of birth:	Sex:	<b>M</b> [
Other:	Other:	Other:			First clinician to print patient name and	check label correct	:
		ouler.					
Sources of me	edicines list	2.1	0		0	Data	0
Source		Date	Confirmed b	y i		Date	Con
General practitioner Practice name:				- I'	Health service/Community Pharmacy Pharmacy name:		
Phone:				- 1	Phone:		
Fax:					Fax:		
Residential care facility					Previous admission		
Care facility name:				- 1	Hospital name:		
Phone:				- 1	Date of discharge:		
Fax:					Date of transfer:		
Patient/carer/family					Patient's own medicines		
Community nurse				!	MyHealth Record		
Patient's own medicines	s list				Dose administration aid device		
				-	☐ Blister pack ☐ Spacer ☐ Sachet ☐ Inhaler		
Other (specify) e.g. pregnancy records							
		ļ					
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