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:

Date of birth: **Sex:** M ☐ F ☐

First clinician to print patient name and check label correct:

.....

Medication Status Legend for Admission Plan, Prescribed and Discharge Plan columns

NEW: new medicine	✓: Continued	△: Changed	✘: Ceased
W: Withheld	↑: Increased dose	↓: decreased dose	CMI: CMI provided
☐: Not charted	POM: Patient's own medicine		

Checklist

- ☐ Oral/liquid ☐ Inhalers ☐ Topical
- ☐ Recreational drugs ☐ Inserted/Instilled ☐ Injections
- ☐ Over-the-counter (OTC) ☐ Complementary ☐ Refrigerated items
- ☐ High risk medicines (HRM) .....
- ☐ Special storage/handling medicine (specify) .....

Changes to medicines in the past 4 weeks e.g antimicrobial course ceased	Reason for change	By whom

Medication History and Reconciliation

☐ Nil regular medicines (confirmed by .....)

Medicine Generic Name/Trade Name, Strength and Form (ie.SR, wafers etc)	Dose, Frequency & Route	Admission Plan (Refer to Legend)		Comments/Indication	Discharge Plan (Refer to Legend)	
		Admission Plan	Prescribed		Plan	Dispense Y/N

NOT FOR ADMINISTRATION

Admission Date: ... / ... / ... Time: ... : ... Date/Time Completed: ... / ... / ... ... : ...

Name: ..... Pager: ... ☐ Prescriber ☐ Pharmacist ☐ Nurse/Midwife

Identified Medication Management Issues

☐ Suspected medicine-related admission

Date/Time	Issue Identified and Proposed Action	Person Responsible	Result of Action
	Issue identified by: ..... Contact number:	Contacted: Y / N	Date: ... / ... / ...
	Issue identified by: ..... Contact number:	Contacted: Y / N	Date: ... / ... / ...
	Issue identified by: ..... Contact number:	Contacted: Y / N	Date: ... / ... / ...
	Issue identified by: ..... Contact number:	Contacted: Y / N	Date: ... / ... / ...

DO NOT WRITE IN THIS BINDING MARGIN

National Medication Management Plan

KEEP WITH ACTIVE MEDICATION CHART – DO NOT REMOVE

Affix patient identification label here and overleaf

Presenting complaint:		
Past medical history:		
Weight (kg):	**Date weighed (DD/MM):** /	Other:
BSA (m^2):	**IBW (kg):**	**Height (cm):**
Serum creatinine on admission (micromol/L):	**Serum creatinine (micromol/L):**	**CrCl (mL/min):**
Other:	Other:	Other:

URN:

Family name:

Given names:

Address:

Date of birth: **Sex:** M ☐ F ☐

First clinician to print patient name and check label correct:

.....

Sources of medicines list

Source	Date	Confirmed by	Source	Date	Confirmed by
☐ **General practitioner** Practice name: Phone: Fax:			☐ **Health service/Community Pharmacy** Pharmacy name: Phone: Fax:		
☐ **Residential care facility** Care facility name: Phone: Fax:			☐ **Previous admission** Hospital name: Date of discharge: Date of transfer:		
☐ **Patient/carer/family**			☐ **Patient's own medicines**		
☐ **Community nurse**			☐ **MyHealth Record**		
☐ **Patient's own medicines list**			☐ **Dose administration aid device** ☐ Blister pack ☐ Spacer ☐ Sachet ☐ Inhaler ☐ Dosette ☐ Other		
☐ **Other (specify)** e.g. pregnancy records					

Medication risk identification (please tick)

Medicines managed by: ☐ Self ☐ Carer/guardian ☐ Relative

Level of independence	Yes	No	Level of independence	Yes	No
Lives alone	☐	☐	Can read/comprehend labels	☐	☐
Lives at residential care facility/group home	☐	☐	Can speak and understand English?	☐	☐
Uses medicines list	☐	☐	Language spoken, if not English:		
Usual mental state impaired on admission	☐	☐	Can open bottles	☐	☐
Swallowing issues	☐	☐	Can measure liquids	☐	☐
Impaired hearing	☐	☐	Recent Medicines Review	☐	☐
Impaired vision	☐	☐	Circle: Home / Residential care Date reviewed: ..... / ..... /		
Other eg. enteral route	☐	☐	Suspected non-adherence	☐	☐

Discharge and transfer medication plan

Education provided to patient (please tick)

- ☐ Interpreter required
- ☐ Written information provided:
  - Patient information: ☐ Hospital ☐ Health ☐ Healthcare Rights
  - Medicines information: ☐ CMI ☐ Other .....
- ☐ Verbal counselling to patient/carer
- ☐ Medicine list provided on discharge
- ☐ Written information about ADRs

Community/Primary Care Liaison (please tick)

- ☐ Patient does **not** accept request to contact GP/Community pharmacy/ACCHO Liaison
- ☐ Copy of medicines list sent to GP/Clinic
- ☐ Liaison with community pharmacy regarding discharge medicines
- ☐ Medicines list/prescription sent to residential care facility
- ☐ Documented discharge plan for anticoagulation management is provided to patient and sent to GP
- ☐ Medication risks are highlighted on patient's medicines list including HRM, allergies and ADRs
- ☐ Dose administration aid required
- ☐ Referred for medication review

Medication reconciliation at discharge (please tick)

- ☐ Discharge medicines reconciled with medicines prescribed at discharge
- ☐ Pharmacist involvement in discharge summary
- ☐ Information uploaded to MyHealth Record

Patient's medicines provided and returned at discharge (please tick)

- ☐ Patient's own medicines (including dose administration aid)
- ☐ Patient's own S8, S4R and Fridge items reviewed

Medicines at discharge

☐ Nil required ☐ Dispensed at hospital ☐ Prescription given to patient ☐ Dose administration aid required. Packed by: .....

Pharmacist comments on discharge medicines

DO NOT WRITE IN THIS BINDING MARGIN

KEEP WITH ACTIVE MEDICATION CHART – DO NOT REMOVE