

COMMONWEALTH OF AUSTRALIA

DEPARTMENT OF HEALTH, DISABILITY AND AGEING

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

INSTRUMENT OF APPROVAL FOR PBS HOSPITAL MEDICATION CHARTS

I, Sam Peascod, Assistant Secretary, Care Integration and Access Branch, Medicare Benefits and Digital Health Division, Health Resourcing Group, Department of Health, Disability and Ageing, 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, Disability and Ageing.

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.

I hereby repeal the instrument of approval as signed by the Assistant Secretary, Pricing and PBS Policy Branch, Technology Assessment and Access Division, Department of Health on 30 April 2019, approving five medication charts for use in Australian hospitals. In its place, I approve the following:

- for the purposes of chart, other than an electronic medication 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)
 - Western Australian PBS Medication Chart (Acute)-use restricted to Western Australian Hospitals only.

This instrument commences on 31 July 2025.

Dated this 31st 2025. day of July

Sam Peascod

Assistant Secretary

Care Integration and Access Branch

Medicare Benefits and Digital Health Division

Health Resourcing Group

Department of Health, Disability and Ageing

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Hospital name.....

Medication chart number.....of

	Provider number						IV fluid Palliative		BGL/i	insulin notherapy	☐ Acu	ute pain neparin	Oth	er
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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

URN:	Not a valid prescription
Family name:	laaa idaadidana muaaant
Given names:	unless identifiers present
Address:	
Date of birth:	Sex: M □ F □
Medicare No:	PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS Safety Net Concession Card Holde	*

First prescriber to print patient name and check label correct:

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Approved pharmacy details:	
Pharmacy approval no:	

Attach ADR sticker

See front page for details

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Attach ADR sticker

Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Reaction / type / date

Medicine (or other)

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 R Safety Net Concession Card I	,

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Date of birth:	Sex: M □ F □
Medicare No:	PBS/RPBS Entitlement No.
☐ Concessional or dependent RPB Safety Net Concession Card Hol	*

Approved pharmacy details:	
Pharmacy approval no:	

Attach ADR sticker

See front page for details

First prescriber to print patient name and check label correct:

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Pri	nt Date		Weight (kg): Height	(cm):

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URN: Family name: Given names: Address:	Not a valid prescription unless identifiers present
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Medicare No:	PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS Safety Net Concession Card Hold	,

Approved pharmacy details:	
Pharmacy approval no:	

Attach ADR sticker See front page for details

First prescriber to print patient name and check label correct:

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Route	Dose and hourly	y frequency	PRN	Time											N/	
Indication		Max PRN dose/24hr		Dose											charge? Y / N days Qty:	ile:
SAC/AAN		Pharmacy		Route											Continue on discharge? Dispense? Y / N Duration:days	r's signati
Prescriber sign	ature	ı		Sign											Continue Dispense Duration:	Prescriber Date:
		cal review:												:		

Cut off section

Medication chart number.....of

Chemotherapy			Palliative							/ard
	Authorit		Initials:		,	nonths	□ 12 n	months	for: □1 month □4 n	art valio
dications/Telephone orders	dica		and p	nes	dici	d med	tiate	rse ini	ce only and nur	Oı
Time/ Time/ Time/ Time/	Date	Prescriber /nurse initiator	nurse initiator	k initials	cy	Frequency	Dose	Route	Medicine (print generic name)/form	/time
Given by Given by Given by		sign	name	N2	N1					
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					+					
Management Plan HRxxx	Man	ation	Medica	on	ons	icatio	med	ission	Jocument admi	
		ils	er Detai	ribe	esc	Pro				

Prescriber Details

l lescriber betails										
	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				

Allergies and adve	ADR sticker erse drug reactions (Al	-	URN: Family name: Given names: Address:	Not a valid prescription unless identifiers present
Medicine (or other)	Reaction / type / date	Initials	Date of birth: Medicare No: Concessional or depende Safety Net Concession C	,
			First prescriber to print patie	ent name and check label correct:
Sian Prin	nt Date		Weight (kg): Height (c	em):

	Medicines	S			Brand su	bstitu	ition no	ot per	mitted		PBS/F	RPBS				Year	Recommended administration times Guidelines only
Variable dos				nd month													Morning Mane 0800
Start Date	Medicine (print ger	neric nam	e)/form		Drug level											z	Night Nocte 1800 (
Route	Froguepov B	'	d 4: d :d: :d	had alasa	Time level taken												Twice a day BD 0800 2000
noute	Frequency Prescri	iber to enter	dose times and individ	iuai dose	Dose	Г										> ZO	Three times a day TDS 0800 1400 2000
Indication		Pharmac	су		Prescriber											Continue on discharge? Dispense? Y / N Duration: days (Prescriber's signature: Date:	Regular 6 hrly 0600 1200 1800
					Time to	├								-		on disc	Regular 8 hrly 0600 1400 2200
Prescriber signatu	ure	SAC/AAN	N		be given	<u> </u>										tinue c ense? ttion: criber'	Four times a day QID 0600 1200 1800
					Nurse initial											Contil Dispe Durat Presc Date:	
VTE risk asses	sed: Yes F	Prophyla	xis not required	d Co	ontraindica	ated		Sign	ature:				1			Date:	
Start Date	Medicine (print gel	neric nam	e)/form			Г											SR = Sustained, modi- or controlled release formulation.
Route	Dose and Freque	ency	and now enter tin	nes —													Tick if slow release If scored tablet, then he can be given.
Indication	VTE proph	ylaxis	Pharmacy													z	Dose must be swallow without crushing.
Prescriber			SAC/AAN													N N S otty:	Anticoagulant education rec
Mechanical proph	nylaxis				AM	\vdash										charge? Y / days ature:	Medicine: Education
					check											on disc	Provided Declined
Signature / NI sig	ure / NI signature Print name Date Marevan / Couma				PM check											Continue on discharge? Dispense? Y / Duration:	Not appropriate Written information
Start Date	Varfarin Print name Warfarin Prescriber to enter individual doses Print name Marevan / Coum Circle brand Target INR Range			umadin	INR												Provided Declined Written information provided:
/	Warfarii	n	Circle brand		Result											z	CMI Other:
Route		r	Target INR Range	е	Dose	mg	g mg	mg	mg	mg	mg	mg	mg	mg	mg	/ Y / Otty:	Signature: Designation: Date:
Indication		Pharmac	CV		Prescriber											harge' / / days ature:	
					Initial 1											n disc	
Prescriber signati	ure				18:00 Initial 2	\vdash										Continue on discharge? Dispense? Y / N Duration: days (Prescriber's signature: Date:	Reason for not administering
	Drescrib	er to en	ter administrati	ion times		=				_				=			Codes MUST be circled
Start Date	Medicine (print ger			Tick if	+												Absent
/			,	slow release		┢										Z	Facility of
Route	Dose and Freque	ency	and now enter tin	nes —>		┝										Continue on discharge? Y Dispense? Y / N Duration: days Gty: Prescriber's signature: Date:	Fasting
Indication		Pharmac	cy		1											scharg Y / mday	On leave
Prescriber signati	ure		SAC/AAN													nue on dis nse? ion: riber's sig	Not available – obtain supply or contact prescriber
																Contir Dispe Durati Presc Date:	Refused – notify prescriber
Start Date	Medicine (print ger	neric nam	e)/form	Tick if slow release												z	Self administered
Route	Dose and Freque	ency	and now enter time	nes —		\vdash										e? Y / N ss Qty:	Vomiting
Indication		Pharmac	су													Continue on discharge? Dispense? Y / N Duration: days Qi Prescriber's signature: Date:	Withheld – enter reason in
Prescriber signatu	ure		SAC/AAN			_										Continue on Dispense? Duration: Prescriber's Date:	clinical record
Pharmaceutical review														∪ .≃	SAC: Streamline Authority Coc		

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			5	Sign			Pri	nt		Date		Weight (k	(g):	Heiç	ght (cm)								,
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/lorning		deline	s onl	y				Presc	riher to e		ate and mo		→										
light	Nocte			1800	or 2000		Start Date	Medicine (print g			Tick										+-	:	ᅥ
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hree times	s TDS	0800	1400	2000		ĺſ	Route	Dose and Frequency	uency	and now e	nter times -	—	_						_		> z	Oty:	
day Regular hourly	6 hrly	0600	1200	1800	2400		Indication	<u> </u>	Dhorma				_								narge?	days ature:	
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our times	QID	0600	1200	1800	2200		Prescriber signat	ure		SAC/AAN											Continue on discharge? Dispense? Y / N	ttion:	
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slow release		ored ta be giv	,	then h	nalf		Indication		Pharma	асу											Continue on discharge? Dispense? Y / N	d signatu	
	Dose	must	be s	wallov	ved		Prescriber signat	LIFO		SAC/AAN		_									ue on o	on: Iber's s	
	witho	out cru	ıshinç	g.		!	riescriber signat	uie		SAC/AAN											Contin	Duratic Prescr	Date:
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	ovided Declined						Route	Dose and Frequency	uency	and now e	nter times —	→									> Z	S Off:	
	ot appropriate						Indication		Pharma	acy		_									charge Y /	day:	
	ritten information rovided Declined												-						_		on dis	r's sign	
Written i							Prescriber signat	ure		SAC/AAN			_		-						Continue on discharge? Dispense? Y / N	ration:	Date:
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Not ava supply o				iber	(N)	╽┟	D 'h '			1040/444											¿əs	n: ber's s	
Refused	d – not	tify pr	escrib	er	R	ĺĺ	Prescriber signat	ure		SAC/AAN											Continue on discharge? Dispense? Y / N	Ouratio Prescri	Date:
		, p				╽┟	Start Date	Medicine (print o	jeneric nar	ne)/form	Tick	if									z		ᅱ
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/omiting	a				(V)	ĺl	Route	Dose and Frequency	uency	and now e	nter times —	→			+						<u>~</u> ≥	Đ.	
		4-					Indication		Pharma	acy											Continue on discharge? Dispense? Y / N	days.	
Withhele clinical			ason	in	W					•											on dist	r's sigr	
						;	Prescriber signat	ure		SAC/AAN								\vdash			ntinue pense'	ration: scribe	te:
SAC: S				-									_								Co	D 2.	Date:
AAN: A	utnorit	y App	oroval	ivuml	ber	ı L				Pharmace	eutical revi	ew:											1

SP

URN: Family name:	Not a valid prescription unless identifiers present
Given names:	annous identification processing
Address:	
Date of birth:	Sex: M □ F □
Medicare No:	PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS Safety Net Concession Card Holde	•

Approved pharmacy details:
Pharmacy approval no:

Attach ADR Sticker See front page for details As required "PRN" medicines

/		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Date							_		
Route	Dose and hourly	frequency	PRN	Time							> Z	 	
Indication		Max PRN dose/	'24hr	Dose							scharge	days Qty: nature:	
SAC/AAN		Pharmacy	Imprest S8 S4R	Route							Continue on discharge? Dispense? Y / N	Duration:aays Prescriber's signature:	
Prescriber signa	ature	•	Print Name	Sign							Continue or Dispense?	Duratio	Date:
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Prescriber signa	ature		Print Name	Sign							Continue on discharge? Dispense? Y / N	Durano Prescri	Date:
Start Date	Medicine (print generic name)/form			Date							Z		
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SAC/AAN		Pharmacy	Imprest S8 S4R	Route							n dis	Duration:	
Prescriber signa	ature		Print Name	Sign							Continue o	Duration: Prescriber	Date:

Check if patient has another medication chart

Cut off section

Hospital P	ame Provider number				Addition	al charts	chart Variable de BGL/insuli Chemothe	ulin Acute pain						
	for: □1 month □	4 months	□ 12 m	nonths	Initials:		Authority F	otion Number						
0	NCE ONLY, PF	E-MED	ICAT	ION AN	D NURSE	/MIDV	/IFE IN	IITIA	TED N	1EDIC	INES			
Date/Time prescribed	Medicine (print generic name)/form	Route	Date/Time of dose	1	riber/Nurse/N	Midwife Initiato Print your na	Given b	Date	:/Time ven	Pharmacy				
	TELEP	HONE (ORDE	ER (to b	e signed	within	24 hοι	ırs o	f orde	r)				
Date/	Medicine	Pouto Pess Fr			Nurse/Midwife	D	ne Dr	Data		ORD OF A	DMINISTR	ATION		
Time	(print generic name)	(print generic name) Route Dose		Frequency	Initials 1st/2nd	Dr nam	Sign	Date	Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by		
See W			(Pre	scribed, over	or to prese the counter, co Administration a	mplementa	ary)							
	Medicine	Dose and fr	requency	Duratio		Medic	cine		Dose and f	requency	Du	ration		
				oo ir	sieti	21	lor							
	Not 10	or a			1104									
GP:	AOL IC	-			Commur	ity pharma	acy:							
Sign:		. Print:			Date:		Medicines	usually a	ıdministere	ed by:				
				Preso	riber Det	ails								
	Prescriber 1	Prescriber 2 Prescri			criber 3	Prescrib	er 4	Pre	escriber 5		Prescril	oer 6		
Name:														
Prescriber No.														
Contact No.														
Address:														
Signature:	Signature	Signat	ture	Sig	nature	Signatu	ıre	S	ignature		Signa	ture		

Check if patient has another medication chart

Date and month

Brand substitution not permitted
PBS/RPBS

				Attac	h AD	R Sticker		URN:		Affix patie	nt identi			and over	leaf escript	ion		
	Г		Allerg Nil know			drug reactions priate box or complete de	• •	Given n	ames:	unless identifiers present								
	Medicine (or other) Reaction / Type / Date Initia					Initials												
	Si	gn		F	Print	Da	ite		criber to					correct:				
Recomme ministratio	n tim			Regula	r Med	licines			and subs	titution ne	ot permit	ted 🗌	PBS/RP	BS		Year		
Guidelines Mane 0800	only		\dashv			Prescriber MUST EN		d month — on times —	→									
locte		1800 or	2000	Start Date	Medicine	(print generic name)/form		Tick if slow	•							z		
BD 0800 TDS 0800	1400	2000		Route	Dose and	d Frequency	and now enter tim	TOTOLOGO								ge? Y / N Nsys Oty:		
-	1200 1400	1800 2200	2400	Indication		Pharmacy	Imprest	st S8 S4R								Continue on discharge? Dispense? Y / N		
QID 0600	1200	1800	2200	Prescriber sign	nature	Print name	SAC/AAN									Continue Dispense Duration:		
			_	Start Date	Medicine	(print generic name)/form		Tick if slow release								z		
SR = Sustain or controlled ormulation.	d rele		ed	Route	Dose and	d Frequency	and now enter tim	es —								harge? Y / N .days Qty:.		
scored tab an be giver	,	hen ha	alf	Indication		Pharmacy	Imprest	S8 S4R								Continue on discharge? Dispense? Y N Duration: ——days Qty		
ose must by the crust the contract of the cont			wed Prescriber signature Print name SAC/AAN													Continue Dispense Duration		
				Start Date	Medicine	(print generic name)/form		Tick if slow								z		
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				Indication		Pharmacy	Imprest	S8 S4R								odiso		
	Prescriber signature Print name SAC/AAN				SAC/AAN									Continue or Dispense? Duration:				

Start Date	Medicine (print generic name)/form	Drug level				Ì				Z	- 1	1	iviorning	Mane U	000	_
/	Wildiania (print goriona name	, 101111	Time level								_ \			Night	Nocte		
Route	Frequency Prescriber to enter d	ose times and individual dose	taken								_ ≻ ~ _~	z Ö		Twice a day		800	\dashv
			Dose								harge	days Qty: ature:		Three tim a day Regular	105 0	_	100
Indication	Pharmacy	rest Prescriber) disc	y sign:		6 hourly Regular	-		200	
Prescriber sign	nature Print name	SAC/AAN	Time to be given								o and	nse? on: riber's		8 hourly Four time	, 1		100
Frescriber sign	nature Frint name	SAC/AAN	Nurse initial								Sonti	Dispense? Y / N Duration:days Qty Prescriber's signature:	Date:	a day	S QID 0	600 12	200
Vanous	Thromboembolism (V)	F) rick assessmen	_	lation	Risk	Assessme	nt Dat	e/Time	Continue	_				l 			
	sk considered (refer guidel		ding risk con			eted by: (na			Y/N	-					SR = Sı	ıctaina	ad r
Pharmacolog	gical Prophylaxis: Indica	ed* Not Indicated surgical and anaesthetic im									Warfa nticoa	 arin/ igulan	,		or controlled releation.		
Mechanical Prophylaxis:		/FP Not Indicated				hanges do	cument VTE ew chart	E prophyla	xis	1	in u Refe	ise		Tick if slow release	If score		et, th
Key: GCS – G	raduated Compression Stocki	ngs; IPC - Intermittent Pn	eumatic Compre	ssion; VFP	– Venou	s Foot Pu	ımps					ion detai			Dose m	_	sw:
Additio	onal Charts – Ti	ck if in use													without	crush	ing.
Blood	I Glucose Level (BGL)	monitoring (Subcutane	ous Insu	lin or	☐ Ir	ntraven	ous Ir	sulin Ir	nfusion)						
☐ Cloza	• • •	• •	us (IV) Fluid			_	nothera										
	tion & arousal	Palliative	care														
	acting injection	☐ Variable o															
Year 20		TE AND MONTH	→														
Prescribe	er MUST ENTER adn	ninistration times	. ▼														
Start Date	Medicine (print generic name	/form Tick	if v								z						
/ Route	Dose and Frequency	and now enter times —	<u>se</u>								>	:: :\d					
											arge?	days Qty: ature:					
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Proporibor pig	nature Print name	SAC/AAN									ne or	nse? ion: riber's		Ι,		nisteri	-
Prescriber sign	nature Print name	SAC/AAN									Conti	Dispe Durati Presc	Date:		Codes MU	151 DE	CIFC
Start Date	Medicine (print generic name	/form	if v								z		Ţ,	Absen	t		
/	D	relea	se									≽		Fasting	g		
Route	Dose and Frequency	and now enter times —									ge?	/ N days Qty: tture:					
Indication	Pharmacy	Imprest S8 S	S4R								discharge?	> : 2		On lea	ve		
Prescriber sig		SAC/AAN									nue on d	Dispense? Duration: Prescriber's sign			ailable – c		crib
	nature Fillit Halfle	JAO/AAN									Sonti	Durat Presc	Date:	Refuse	ed – notify	presc	ribe
Start Date	Medicine (print generic name	/form Tick slov relea	if v se								z			Self ac	dministere	d	
Route	Dose and Frequency	and now enter times —	-								> >	/ N .days Qty: . .ture:					
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Indication	Pharmacy	Imprest S8 S	S4R		-						e on disc	Dispense? Y / N Duration:days Qt Prescriber's signature:			eld – enter I record	reaso	n in
Prescriber sign	nature Print name	SAC/AAN									ontinu	Dispent Turation Trescrit	Date:	040	Otro o !!	Λ	
										0 (_ <u></u>	: 🗅		Streamline Authority		-	

	Sta
	Roi
Reason for not administering	Indi
Codes MUST be circled	Pre
Absent (A)	Sta
Fasting (F)	
	Roi
On leave (L)	Indi
Not available – obtain supply or contact prescriber N	Pre
Refused – notify prescriber R	
Self administered S	Sta
Vomiting V	Roi
Withheld – enter reason in clinical record	Indi
	Pre
SAC: Streamline Authority Code	
AAN: Authority Approval Number	

Regula	Brand substitution not permitted PBS/RPBS								 Year					
		Prescriber MUST FNT	Date and month											
Start Date	Medicine	(print generic name)/form	Tick if	*	Н							Н	z	┪
/			slow release					+					_	
Route	Dose and	Frequency	and now enter times										discharge? Y Y / N Y days Qty	
Indication		Pharmacy	Imprest S8 S4R										on discha Y , da 's signatu	
Prescriber sign	nature	Print name	SAC/AAN					\vdash					Continue on discharge? N Dispense? Y / N Duration:days Qity Prescriber's signature:	Date:
Start Date	Medicine	(print generic name)/form	Tick if slow release										z	
Route	Dose and	d Frequency	and now enter times										discharge? Y Y / N Y days Qty:	
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Prescriber sign	nature	Print name	SAC/AAN					\vdash					Sontinue o Dispense? Duration:	Date:
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Start Date	Medicine	(print generic name)/form	Tick if slow release										Z	
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Route	Dose and	Frequency	and now enter times										charge? Y Y / N days Qty:	
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Prescriber sign	nature	Print name	SAC/AAN					+					ontinue o ispense? uration: rescriber's	ate:

Check if patient has another medication chart

Check if patient has another medication chart

Pharmaceutical review:

Regular Medicines

Variable dose medicine