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:

(a) 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 day of July 2025.

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

Cut off section

Cut off section

PBS Hospital Medication Chart (Long Stay)

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:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

PBS Hospital Medication Chart (Long stay) © Commonwealth of Australia 2016 – As amended 2019 (Version 1.1)

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:

....

Approved pharmacy details:

....

Pharmacy approval no:

....

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													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

SP

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): ....

Cut off section

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
Indication		Pharmacy	Prescriber
Prescriber signature			Initial 1 18:00
			Initial 2

Dose: mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg mg

Continue on discharge? Y / N
Dispense? Y / N
Duration: ....days Qty: ....
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
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:

DO NOT WRITE IN THIS BINDING MARGIN

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	Ⓐ
Fasting	Ⓕ
On leave	Ⓛ
Not available – obtain supply or contact prescriber	Ⓝ
Refused – notify prescriber	Ⓡ
Self administered	Ⓢ
Vomiting	Ⓥ
Withheld – enter reason in clinical record	Ⓦ

SAC: Streamline Authority Code
AAN: Authority Approval Number

Check if patient has another medication chart **Check if patient has another medication chart**

Cut off section

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

First prescriber to print patient name and check label correct:

....

Approved pharmacy details:

....

Pharmacy approval no:

....

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: ....

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart A (Acute) © Commonwealth of Australia 2016 – As amended 2019 (Version 1.1)

Cut off section

PBS Hospital Medication Chart A (Acute)

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

Not for administration

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:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

SP

Cut off section

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): ....

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
Duration: ....days Qty: ....
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
AM check
Signature / NI signature Print name
PM check

Continue on discharge? Y / N
Dispense? Y / N
Duration: ....days Qty: ....
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
Duration: ....days Qty: ....
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
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

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	Ⓐ
Fasting	Ⓕ
On leave	Ⓛ
Not available – obtain supply or contact prescriber	Ⓝ
Refused – notify prescriber	Ⓡ
Self administered	Ⓢ
Vomiting	Ⓥ
Withheld – enter reason in clinical record	Ⓦ

SAC: Streamline Authority Code
AAN: Authority Approval Number

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:

SP

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: ....

First prescriber to print patient name and check label correct:

....

Attach ADR sticker

See front page for details

Cut off section

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:

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart B (Acute) © Commonwealth of Australia 2016 – As amended 2019 (Version 1.1)

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 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:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

PBS Hospital Medication Chart B (Acute)

SP

Cut off section

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

Not a valid prescription unless identifiers present

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

First prescriber to print patient name and check label correct:

....

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

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
Duration: ......days Qty: ......
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
Duration: ......days Qty: ......
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
Duration: ......days Qty: ......
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
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

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	Ⓐ
Fasting	Ⓕ
On leave	Ⓛ
Not available – obtain supply or contact prescriber	Ⓝ
Refused – notify prescriber	Ⓡ
Self administered	Ⓢ
Vomiting	Ⓥ
Withheld – enter reason in clinical record	Ⓦ

SAC: Streamline Authority Code
AAN: Authority Approval Number

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
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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

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:
....

Approved pharmacy details:
....
Pharmacy approval no:
....

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													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	Impress 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	Impress 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	Impress S8 S4R	Route													
Prescriber signature		Print Name	Sign													
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Route	Dose *and* hourly frequency	**PRN**	Time													
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SAC/AAN	Pharmacy	Impress S8 S4R	Route													
Prescriber signature		Print Name	Sign													
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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	Impress S8 S4R	Route													
Prescriber signature		Print Name	Sign													
	Pharmaceutical review:															

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Cut off section

PBS Hospital Medication Chart A (Acute) © Commonwealth of Australia 2016 – As amended 2023 (WA Version 3)

Hospital name..
Hospital Provider number..
Ward...Team...

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

Additional charts
☐ IV fluid
☐ Palliative care
☐ Variable dose
☐ BGL/insulin
☐ Chemotherapy
☐ Other (Refer to checklist on page 2)
☐ Acute pain
☐ 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		Given by	Date/Time Given	Pharmacy
					Signature	Print your name			

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

Not for administration

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:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

HCCXXX

XXXX
11/23

Check if patient has another medication chart

WA Hospital Medication Chart – Short Stay

MR XXX

SP

Cut off section

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 ☐
Medicare No: PBS/RPBS Entitlement No.

Not a valid prescription unless identifiers present

☐ 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:...../...../.....

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year _____

Variable dose medicine — Date and month →

Start Date ..... / ..... | Medicine (print generic name)/form | Drug level
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

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

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	Continue Y / N

If risk changes document VTE prophylaxis requirements on new chart

☐ **Warfarin / Anticoagulant in use**
Refer to Anticoagulation Chart for administration details

Additional Charts – Tick if in use

☐ Blood Glucose Level (BGL) monitoring (☐ Subcutaneous Insulin or ☐ Intravenous Insulin Infusion)
☐ Clozapine ☐ Intravenous (IV) Fluid ☐ Chemotherapy
☐ Agitation & arousal ☐ Palliative care ☐ Acute Pain
☐ Long acting injection ☐ Variable dose ☐ Other .....

Year 20..... **DATE AND MONTH** →
Prescriber MUST ENTER administration times ↓

Start Date ..... / ..... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency and now enter times →
Indication | Pharmacy | Imprest 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:

Recommended administration times
Guidelines only

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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
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

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year _____

Date and month →
Prescriber MUST ENTER administration times →

Start Date ..... / ..... | Medicine (print generic name)/form | Tick if slow release
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Prescriber signature | Print name | SAC/AAN

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

Check if patient has another medication chart

Check if patient has another medication chart

SP