

AFFIX PATIENT IDENTIFICATION LABEL	
UR No.	NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT
Family Name:	
Given Names:	
DOB:	Sex ☐ M ☐ F

Sex ☐ M ☐ F

Attach ADR Sticker

See front page for details

1st Prescriber to Print Patient Name and Check Label Correct: ☐

Year 20 _____

Private Hospital NIMC

11 DAY VERSION

[illegible]

BINDING MARGIN - DO NOT WRITE

MEDICATION CHART MB

WARFARIN ORDERING SECTION

Patient Name 1st 2nd			PBS RPBS () Appropriate box		DOSE TIME 1800 6pm	INR Result													
Date	WARFARIN Brand of Warfarin (Circle) Marevan / Coumadin					DOSE	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg	mg
Route	Target INR					Doctor													
Prescriber Name	Prescriber No.	Prescriber Signature	Contact			Nurse 1													
Indication		Pharmacy	Quantity	Repeats	Nurse 2														
					Discharge Required	Yes / No		Duration/Quantity		Dr. Signature									

For **each day of therapy**, the following information should be documented:

- INR result.
- warfarin dose
- doctor's initials
- initials of nurse that administers the dose and the checking nurse.

Because of the well documented risks associated with use of warfarin, all patients should receive counselling about the use of warfarin and given a warfarin book (*available from Sigma pharmaceuticals*). This section is included as a record that these risk mitigation activities have been completed.

Prescribing:

- Dose and hourly frequency. "PRN" (pre-printed) alone is not sufficient.
- Indication and maximum daily dose (ie maximum dose in 24 hours) *eg Paracetamol 4g/24 hrs*

Administration:

The person administering each dose is responsible for checking that the maximum daily dosage will not be exceeded.

[illegible]

ALLERGIES & ADVERSE REACTIONS (ADR)		
Nil known	Unknown (tick appropriate box or complete details below)	
Drug (or other)	Reaction/Type/Date	Initials

Sign Print Date

VARIABLE DOSE MEDICINES

Patient Name 1st		2nd		PBS RPBS () Appropriate box		DOSE TIME	Drug Level												
Date	Medication (Use Generic Name) Print						Time Level Taken												
Route	Frequency						DOSE												
Dr to enter Dose Time & Individual Dose							Doctor												
Prescriber Name		Prescriber No.		Prescriber Signature		Contact	Time Given												
Indication		Pharmacy		Quantity		Repeats	Nurse												
							Discharge Required	Yes / No		Duration/Quantity		Dr. Signature							

- Dose.
- Doctor's initials
- Actual time of administration (this may be different from the dose time)
- Initials of nurse that administers the dose.

If a patient requires a second variable dose medication or twice daily dosing prescribe in the regular section using the above format.

REASON FOR NURSE NOT ADMINISTERING CODES MUST BE CIRCLED		RECOMMENDED ADMINISTRATION TIMES (GUIDELINES ONLY)								COMMONLY USED AND UNDERSTOOD ABBREVIATIONS	
										Abbreviation	Meaning
Absent	(A)	Morning	Mane	0800						PO	per oral / by mouth
Fasting	(F)	Night	Nocte					1800 or 2000		NG	nasogastric
On Leave	(L)									sublingual	sublingual
Not available - obtain supply or contact Dr	(N)									IV	intravenous injection
Refused - Notify Dr	(R)									IM	intramuscular injection
Self Administering	(S)	Twice A Day	BD	0800	2000					subcutaneous	subcutaneous
Vomiting	(V)	Three Times A Day	TDS	0800	1400	2000				IT	intrathecal
Withheld - enter reason In Clinical Record	(W)	Four Times A Day	QID	0600	1200	1800	2200			PR	per rectum
		Six Times A Day	4 Hourly	0200	0600	1000	1400	1800	2200	PV	per vagina
		Antibiotic 6 Hourly	6 Hourly	0600	1200	1800	2400			Gutt	eye drop
		Antibiotic 8 Hourly	8 Hourly	0600	1400	2200				Occ	eye ointment
										Top	topical
										MA	metered aerosol
										Neb	nebulised / nebuliser
										PCA	patient controlled analgesic

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.

RECOMMENDED WAY OF CHARTING MEDICATIONS TO BE GIVEN LESS FREQUENTLY THAN DAILY

[illegible]

DOCTOR: Please Press Firmly -
Pharmacy Prescriptions underneath

[illegible]

REASON FOR NURSE NOT ADMINISTERING Codes MUST be circled
Absent
Fasting
Refused - notify Dr
Vomiting
On leave
Not available - obtain supply or contact Dr
Withheld - Enter reason in Clinical Record
Self Administering

Date	Patient Name 1st 2nd	☐ PBS ☐ RPBS (✓) Appropriate box												
Drug (Generic Name)		Tick if Slow release	Route	Dose	Frequency									
☐ Brand substitution not permitted														
Print Prescriber Name	Prescriber No.	Prescriber Signature			Contact									
Indication			Pharmacy	Quantity	Repeats	Discharge Required	Yes / No		Duration/ Quantity		Dr. Signature			

PHARMACY PRESCRIPTION

Patient Name 1st2nd		☐ PBS ☐ RPBS (✓) Appropriate box	DOSE TIME	
Date	Medication (Use Generic Name) Print			
Route	Frequency			
Dr to enter Dose Time & Individual Dose				
Print Prescriber Name		Prescriber No.	Prescriber Signature	Contact
Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats	

PHARMACY PRESCRIPTION

Patient Name 1st2nd		☐ PBS ☐ RPBS (✓) Appropriate box	DOSE TIME	
Date	WARFARIN Brand of Warfarin (Circle) Marevan / Coumadin			
Route	Target INR			
Print Prescriber Name		Prescriber No.		Prescriber Signature
Medicare Australia/DVA copy - Valid for use as PBS at:		Quantity	Repeats	

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Date	Medication (Use Generic Name) Print			
Route	Frequency			
Dr to enter Dose Time & Individual Dose				
Print Prescriber Name		Prescriber No.	Prescriber Signature	Contact
Pharmacist/Patient copy - Valid for use with PBS Repeat Authorisation			Quantity	Repeats

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AS REQUIRED "PRN" MEDICATIONS	
Year 20 _____	

Year 20 _____

Date	Patient Name 1st 2nd	PBS RPBS () Appropriate box		
Drug (Generic Name) Brand substitution not permitted	Tick if Slow release	Route	Dose	Hourly Frequency PRN
Prescriber Name	Prescriber No.	Prescriber Signature		Contact
Indication		Pharmacy	Quantity	Repeats

DATE	TIME	DOSE	ROUTE	SIGN	DATE	TIME	DOSE	ROUTE	SIGN	DATE	TIME	DOSE	ROUTE	SIGN
Discharge Required					Duration/Qty					DR Initials				
Yes / No														

Date	Patient Name 1st 2nd			PBS RPBS () Appropriate box
Drug (Generic Name)	Tick if Slow release	Route	Dose	Hourly Frequency PRN
Brand substitution not permitted				
Prescriber Name	Prescriber No.	Prescriber Signature		Contact
Indication		Pharmacy	Quantity	Repeats

Discharge Required Yes / No
Duration/
Qty
DR Initials

Date	Patient Name 1st 2nd			PBS RPBS () Appropriate box
Drug (Generic Name)	Tick if Slow release	Route	Dose	Hourly Frequency
Brand substitution not permitted				PRN
Prescriber Name	Prescriber No.	Prescriber Signature		Contact
Indication		Pharmacy	Quantity	Repeats

[illegible]

Date	Patient Name 1st 2nd	PBS RPBS () Appropriate box			
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Prescriber Name		Prescriber No.		Prescriber Signature	Contact
Indication			Pharmacy	Quantity	Repeats

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Indication		Pharmacy		Quantity	Repeats

Discharge
Required Yes / No
Duration/
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DR
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DOCTOR: Please Press Firmly - Pharmacy Prescriptions underneath
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MEDICATION CHART

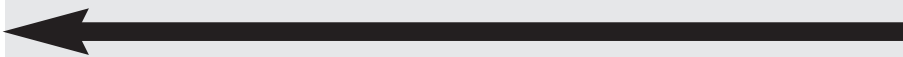
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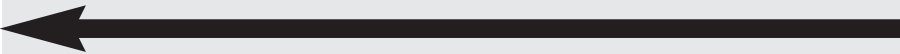
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