Attach ADR sticker | **Diabetic on insulin**

Affix patient identification label here and over leaf

UR No

Family name:
Given names:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Address:

DOB:

Sex ☐ **M** ☐ **F**

Allergies and adverse reactions (ADR)

☐ **Nil known** ☐ **Unknown** (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Medication chart _____ of _____

Weight (kg) _____ Height (cm) _____

IV fluid administration

Date	No	Type of fluid (including strength)	Amount	Time	Additions to flask	Prescriber's signature	Administration				
							Start date	Start time	Finished time	Total infused	RN signature

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (print generic name)	Route	**Dose**	Date / time of dose	Prescriber / Nurse Initiator (NI)		Given by	Time given
					Signature	Print name		

Telephone orders (to be signed within 24 hours of order)

Date / time	Medicine (print generic name)	Route	**Dose**	Frequency	Check initials		Prescriber name	Prescriber signature	Date	Record of administration
					N1	N2				Time / given by

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Medicines taken prior to presentation to hospital
(Prescriber, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

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See front page for details

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Address:

DOB: **Sex** ☐ **M** ☐ **F**

Year 20 ______

Date	Patient name 1st 2nd			☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) Tick if slow release ☐ Brand substitution not permitted		Route	Dose	Hourly frequency
Prescriber name	Prescriber No	Prescriber signature		Contact
Indication		Pharmacy	Quantity	Repeats

Date											Continue on discharge? Yes / No
Time											Dispense? Yes / No
Dose											Duration: ....days
Route											Qty: ....
Sign											

Date	Patient name 1st 2nd			☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) Tick if slow release ☐ Brand substitution not permitted		Route	Dose	Hourly frequency
Prescriber name	Prescriber No	Prescriber signature		Contact
Indication		Pharmacy	Quantity	Repeats

Date											Continue on discharge? Yes / No
Time											Dispense? Yes / No
Dose											Duration: ....days
Route											Qty: ....
Sign											

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Indication		Pharmacy	Quantity	Repeats

Date											Continue on discharge? Yes / No
Time											Dispense? Yes / No
Dose											Duration: ....days
Route											Qty: ....
Sign											

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Sign											