<table>
<thead>
<tr>
<th>Date</th>
<th>Medicine (print generic name)</th>
<th>Route</th>
<th>Dose</th>
<th>Date/time of dose</th>
<th>Prescriber/Nurse Initiator (NI)</th>
<th>Given by</th>
<th>Time given</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Once only and nurse initiated medicines and pre-medications**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medicine (print generic name)</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
<th>Check initials</th>
<th>Prescriber name</th>
<th>Time / given by</th>
<th>Record of administration</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Medicine (print generic name)</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
<th>T1</th>
<th>T2</th>
<th>Size</th>
<th>Date</th>
<th>Time / given by</th>
<th>Time / given by</th>
<th>Time / given by</th>
<th>Time / given by</th>
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</tbody>
</table>

**Medicines taken prior to presentation to hospital** (Prescribed, over the counter, complementary)

<table>
<thead>
<tr>
<th>Own medicines brought in?</th>
<th>Y</th>
<th>N</th>
<th>Administration aid (specify)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Medicine</th>
<th>Dose and frequency</th>
<th>Duration</th>
<th>Medicine</th>
<th>Dose and frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**NIMC (acute)**

<table>
<thead>
<tr>
<th>PRN</th>
<th>Date</th>
<th>Time</th>
<th>Given by</th>
<th>Sign</th>
<th>Print</th>
<th>Date</th>
<th>Medicines usually administered by:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**National Medication Chart – 01/2012 – © Commonwealth of Australia 2005 – As amended 2012**

*Not a valid prescription unless identifiers present*
<table>
<thead>
<tr>
<th>Date</th>
<th>Medicine (print generic name)</th>
<th>Time level taken</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency and NOW enter times</th>
<th>VTE prophylaxis</th>
<th>Prescriber/NI signature</th>
<th>Print your name</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Drug release**
- Continue on discharge? Yes / No
- Dispense? Yes / No
- Duration: ____________________________
- Prescriber’s signature: ____________________________
- Print your name: ____________________________
- Pharmacist: ____________________________
- Date: ____________________________

**Allergies and adverse drug reactions (ADR)**
- Known: ____________________________
- Nil known: ____________________________
- Date: ____________________________
- Sign: ____________________________

**Patient education**
- Date: ____________________________
- Given warfarin book: ____________________________
- Patient educated by: ____________________________
- Date: ____________________________
- Sign: ____________________________

**Guidelines only**
- Codes MUST be circled
- Dose must be swallowed
- Can be given.
- If scored tablet, then half formulation.
- SR = Sustained, modified release
- Recommended

**Prescription label**
- Print and check label correct.
- Not a valid identifiers present.
- Affix patient identification label here and overleaf.
- First prescribed to print patient name.
- Date of birth: ____________________________
- Address: ____________________________
- Given names: ____________________________
- Family name: ____________________________
- URN: ____________________________
- Sex: ____________________________
- Height (cm): ____________________________
- Weight (kg): ____________________________

**Cut off section**
- Attach ADR sticker
- Date: ____________________________
- Sign: ____________________________

**Pharmaceutical review (or other)**
- Date: ____________________________
- Sign: ____________________________

**Note:**
- Drug release: Dispense? Yes / No
- Continue on discharge? Yes / No
- Duration: ____________________________
- Prescriber’s signature: ____________________________
- Print your name: ____________________________
- Pharmacist: ____________________________
- Date: ____________________________

**Prescriber’s signature**
- Date: ____________________________
- Print your name: ____________________________
- Contact: ____________________________

**Regular medicines**
- Date and month: ____________________________
- Prescriber MUST ENTER administration times
- Reminder: Do not omit administration times.

**VTE prophylaxis**
- Yes
- No
- Prescribed
- Not required
- Contraindicated

**Warfarin**
- Warfarin
- Marevan / Coumadin
- VTE prophylaxis
- VTE risk assessed: Yes
- Prophylaxis not required
- Mechanical prophylaxis

**Clinical record**
- Date: ____________________________
- Sign: ____________________________

**Preparatory instructions**
- Fasting
- Absent
- Weight (kg): ____________________________
- Do NOT administer if: ____________________________