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:

Attach ADR sticker

See front page for details

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UR No

Family name:
Given names:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Address:

DOB:

Sex ☐ **M** ☐ **F**

REMOVED AREA

Pharmacy prescription

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	Medicare Australia / DVA copy – valid for use as PBS at:		Quantity	Repeats

Pharmacy prescription

Pharmacy prescription

Date	Patient name 1st 2nd			☐ PBS ☐ RPBS (✓) Appropriate box
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Indication	Medicare Australia / DVA copy – valid for use as PBS at:		Quantity	Repeats

Pharmacy prescription

REMOVED AREA

Pharmacy prescription

Date	Patient name 1st 2nd			☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route	Dose	Hourly frequency
Prescriber name	Prescriber No	Prescriber signature		Contact
Indication	Pharmacist / patient copy – valid for use with PBS repeat authorisation		Quantity	Repeats

Pharmacy prescription

Pharmacy prescription

Date	Patient name 1st 2nd			☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route	Dose	Hourly frequency
Prescriber name	Prescriber No	Prescriber signature		Contact
Indication	Pharmacist / patient copy – valid for use with PBS repeat authorisation		Quantity	Repeats

Pharmacy prescription

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Indication	Pharmacist / patient copy – valid for use with PBS repeat authorisation		Quantity	Repeats

Pharmacy prescription

REMOVED AREA

Year 20 ______

PRESCRIBER: please press firmly – pharmacy prescriptions underneath

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

Date											
Time											
Dose											
Route											
Sign											

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....

PRESCRIBER: please press firmly – pharmacy prescriptions underneath

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

Date											
Time											
Dose											
Route											
Sign											

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....

PRESCRIBER: please press firmly – pharmacy prescriptions underneath

Date	Patient name 1st	2nd		☐ PBS ☐ RPBS (✓) Appropriate box
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Indication		Pharmacy	Quantity	Repeats

Date											
Time											
Dose											
Route											
Sign											

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....

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Date											
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Date											
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Dispense? Yes / No
Duration: ....days Qty: ....