

The National Residential Medication Chart (NRM/C) was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) to facilitate the direct supply and claiming from a medication chart of most medicines under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS), and to define national standards for medication charts in residential care facilities.

Further information may be obtained at www.safetyandquality.gov.au or by emailing medsafety@safetyandquality.gov.au



Further information

The information on this form, including your Medicare, Centrelink and/or Department of Veterans' Affairs number, will be used to assess your entitlement to benefits under the Pharmaceutical Benefits Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS) and to determine payments due to approved suppliers. This information will also be used to record details of an under co-payment prescription (where there is no entitlement to a payment of benefit under PBS or RPBS). With your consent, the PBS approved supplier or PBS Prescriber may store your details for use on future prescriptions. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to PBS Prescribers, the Department of Health and Ageing, Department of Veterans' Affairs, Centrelink, the Department of Human Services or as authorised or required by law. This information will be handled in accordance with the provisions in the *Privacy Act 1988* (Cth) (the **Privacy Act**).

Privacy statement

<h3 style="margin: 0;">National Residential Medication Chart v.4</h3> <p style="margin: 0;">AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE</p>	<div style="border: 2px solid red; padding: 5px; margin-bottom: 10px;"> <p style="color: red; font-weight: bold; margin: 0;">ALERT</p> <p style="color: red; font-size: small; margin: 0;">Consumer with similar name?</p> <p style="color: red; font-weight: bold; margin: 0; text-align: center;">Y / N</p> </div> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Consumer name _____</td> <td style="width: 50%;"></td> </tr> <tr> <td>Preferred name _____</td> <td></td> </tr> <tr> <td>Date of Birth / / _____</td> <td>Gender _____ Photo date / / _____</td> </tr> <tr> <td>URN/MRN _____</td> <td>IHI _____</td> </tr> <tr> <td>RACS ID _____</td> <td>RACF name _____</td> </tr> </table> <div style="text-align: center; border: 1px solid gray; padding: 10px; width: 100px; margin: 10px auto;"> <p style="font-size: small;">Insert photo</p> </div>	Consumer name _____		Preferred name _____		Date of Birth / / _____	Gender _____ Photo date / / _____	URN/MRN _____	IHI _____	RACS ID _____	RACF name _____				
Consumer name _____															
Preferred name _____															
Date of Birth / / _____	Gender _____ Photo date / / _____														
URN/MRN _____	IHI _____														
RACS ID _____	RACF name _____														
<p style="color: red; font-weight: bold; margin: 0;">CONSIDERATIONS</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Swallowing difficulties</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Cognitive impairment</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Dexterity difficulties</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Resistive to medicine</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Nil by mouth</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Self administers</td> <td style="text-align: right;">Y / N</td> </tr> <tr> <td>Other</td> <td style="text-align: right;">Y / N</td> </tr> </table> <p style="font-size: small; margin: 0;">Details if Y to above: _____</p> <p style="margin: 0;">_____</p> <p style="margin: 0;">_____</p> <p style="margin: 0;">Non packed medicines <input type="checkbox"/></p>	Swallowing difficulties	Y / N	Cognitive impairment	Y / N	Dexterity difficulties	Y / N	Resistive to medicine	Y / N	Nil by mouth	Y / N	Self administers	Y / N	Other	Y / N	<div style="border: 1px solid blue; padding: 5px; margin-bottom: 5px;"> <p style="color: blue; font-weight: bold; margin: 0;">PRIMARY GENERAL PRACTITIONER</p> <p>Name _____</p> <p>Address _____</p> <p>Phone _____ Fax _____</p> <p>Out of hours _____</p> <p>Prescriber number _____</p> <p>Email _____</p> <p style="font-weight: bold; margin: 0;">Signature _____</p> </div> <div style="border: 1px solid blue; padding: 5px; margin-bottom: 5px;"> <p style="color: blue; font-weight: bold; margin: 0;">PRESCRIBER details (if not primary GP)</p> <p>Name _____</p> <p>Address _____</p> <p>Phone _____ Fax _____</p> <p>Out of hours _____</p> <p>Prescriber number _____</p> <p>Email _____</p> <p style="font-weight: bold; margin: 0;">Signature _____</p> </div> <div style="border: 1px solid blue; padding: 5px; margin-bottom: 5px;"> <p style="color: blue; font-weight: bold; margin: 0;">PRESCRIBER details (if not primary GP)</p> <p>Name _____</p> <p>Address _____</p> <p>Phone _____ Fax _____</p> <p>Out of hours _____</p> <p>Prescriber number _____</p> <p>Email _____</p> <p style="font-weight: bold; margin: 0;">Signature _____</p> </div>
Swallowing difficulties	Y / N														
Cognitive impairment	Y / N														
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Self administers	Y / N														
Other	Y / N														
<div style="border: 1px solid red; padding: 5px; margin-bottom: 5px;"> <p style="color: red; font-weight: bold; margin: 0;">ALERT: Complex medications</p> <p style="font-size: small; margin: 0;">Variable dose Y / N</p> <p style="font-size: small; margin: 0;">Insulin Y / N</p> <p style="font-size: small; margin: 0;">Other Y / N (specify): _____</p> </div> <p style="font-size: small; margin: 0;">Medicare number _____</p> <p style="font-size: small; margin: 0;">Pension number _____</p> <p style="font-size: small; margin: 0;">DVA number _____</p>	<p style="font-size: small; margin: 0;">Chart commenced ___/___/___ Expiry date ___/___/___</p> <p style="font-size: small; margin: 0;">Review date ___/___/___ Maximum chart validity is 4 months from the date the chart is commenced</p> <div style="border: 1px solid gray; padding: 5px; margin-top: 5px;"> <p style="font-weight: bold; margin: 0;">PHARMACY</p> <p>Name _____</p> <p>Phone _____ Fax _____</p> <p>Email _____</p> </div>														
	<p style="font-size: small; margin: 0;">RACF Name _____</p> <p style="font-size: small; margin: 0;">RACF Address _____</p> <p style="font-size: small; margin: 0;">_____</p>														
	<p style="font-size: large; font-weight: bold; margin: 0;">Chart of </p>														

Front page MUST be sent to pharmacy on each change

! Allergies and Adverse Drug Reactions (ADR) Y / Nil known

Drug (or other)	Reaction / type / date

Sign _____ Print _____ Date ____/____/____

ALERT
Consumer with similar name?
Y / N

Consumer name _____
Preferred name _____
Date of Birth / / Gender Photo date / /
URN/MRN IHI
RACS ID RACF name

Insert photo

(W) Withheld (clinical reason) (S) Sleeping (C) Contraindicated (R) Refused (A) Absent (N) Not available

Nutritional supplement intake and weight monitoring (under 80kgs)

Start date ____/____/____

Stop date ____/____/____

Valid for duration of chart

OR

Stop date ____/____/____

Nutritional supplement _____

Dose _____

Route _____

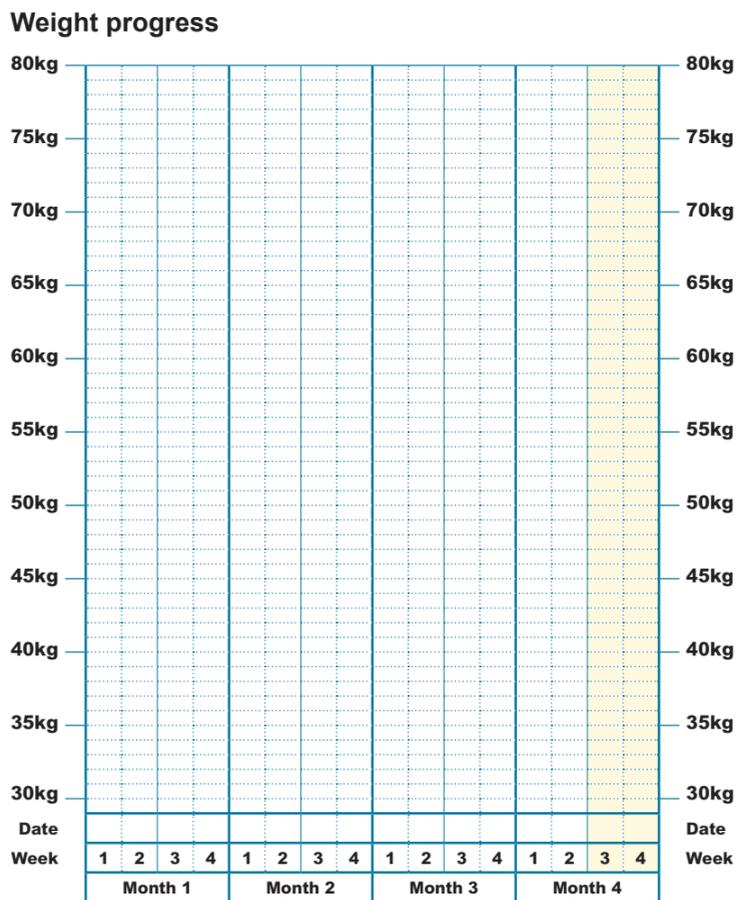
Frequency _____

Additional instructions _____

PBS/RPBS CTG
Brand substitution not permitted

Prescriber signature and name _____
Date of prescribing ____/____/____

Non packed



Comments

Nutritional supplement directions
(if ordered by dietician or registered nurse)

Intake
Enter amount of nutritional supplement taken per shift as morning/lunch ☀️ and afternoon/evening 🌙.

For example, one cup = 1 serve; half a cup = ½ serve; one third cup = ⅓ serve.

Weight progress
Plot weight on chart by using a dot to indicate weight progress.

BMI

Review and evaluation

Name _____

Designation _____

Prescribing and administration

For prescribers

PBS/RPBS: Strike through the option which does not apply. If private (non-PBS), strike out both PBS and RPBS.

Brand substitution not permitted: Indicate if the specified brand must be supplied by ticking the box.

CTG: Closing the Gap PBS Co-payment initiative for registered Aboriginal and Torres Strait Islander people. If applicable, tick the box.

Streamlined authority code: write the streamlined authority code in the spaces provided, where applicable. Streamlined authority codes are available at www.pbs.gov.au

Remember: Certain PBS/RPBS medicines will still require a written prescription from the prescriber, in addition to an order on the medication chart, including:

- all Authority required items requiring prior approval (including PBS/RPBS items with increased quantities and/or repeats)
- all items only available under special arrangements (Section 100)
- Controlled Drugs (Schedule 8 medicines).

Commonly used abbreviations in residential care

Route

PO: per oral (via the mouth e.g. tablets)

PR: per rectum (via the rectum e.g. suppository for constipation)

topical: per the skin (applied to the skin e.g. cream)

subcut: subcutaneous (an injection into the upper skin layers e.g. insulin)

subling: sublingual (under the tongue)

NG: nasogastric (via a specialised tubing inserted into the nose e.g. nutritional supplements)

PEG: percutaneous enteral gastrostomy (via a specialised tubing inserted into the stomach e.g. nutritional supplements)

IM: intramuscular (an injection into the muscle e.g. influenza vaccination)

IV: intravenous (a fluid inserted via an inserted line into a vein)

Frequency (suggested times most commonly used in residential care)

mane: morning (e.g. breakfast)

nocte: night (e.g. dinner)

bd: twice per day (e.g. breakfast and dinner)

tds: three times per day (e.g. breakfast, lunch and dinner)

qid: four times per day (e.g. breakfast, lunch, dinner and bed time)

The six rights of medicine administration

- Right consumer
- Right medicine
- Right dose
- Right time
- Right route
- Right documentation

Abbreviations when medicine not administered

(W) Withheld (clinical reason)

(S) Sleeping

(C) Contraindicated

(R) Refused

(A) Absent

(N) Not available

Reason for PRN Administration

(At) Agitation

(Ag) Aggression

(Ps) Psychosis

(H) Hallucinations

(Wa) Wandering

(P) Pain

(Co) Constipation

(NV) Nausea / Vomiting

(Z) Sleep

Please refer to supplemental information provided within the NRMCM user guides:

NRMCM – Nurse User Guide

NRMCM – User guide for prescribers



Prescriber checklist



1 Consumer Identification Panel

! Allergies and Adverse Drug Reactions (ADR) Y / Nil known	
Drug (or other)	Reaction / type / date
Sign	Date

ALERT	Consumer name John Richard Brown
Consumer with similar name?	Preferred name John
Y / N	Date of Birth 07/01/1935 Gender M Photo date 02/08/20
	URN/MRN L979797 IHI 289897248602
	RACS ID 04123 RACF name

These fields **MUST** be completed for the NRM to be a valid prescription. This is often pre populated by the residential care facility.

2 Prescriber Information

PRIMARY GENERAL PRACTITIONER
Name Dr Joseph Smith
Address 123 Apple Avenue, Moree NSW 2063
Phone 9123 4567 Fax 9123 4568
Out of hours 9123 4569
Prescriber number X122334456
Email name.surname@healthservice.com.au
Signature <i>Joseph Smith</i>

These fields **MUST** be completed to be a valid prescription. This is often pre populated by the residential care facility.

Each chart **MUST** be signed by the prescriber.

3 Essential Prescription Fields required for a valid prescription

All fields circled in **RED** must be completed by a prescriber to enable a pharmacist to supply and claim for a PBS/RPBS medicine. All fields circled in **GREEN** are to be completed by the prescriber where applicable.

The prescriber **MUST** fill a start and indicate a stop start date by either ticking the valid for duration of chart or a stop date.

Start date <i>01/01/21</i>	1. Medicine/form/strength <i>Digoxin Oral liquid</i>	Dose <i>5ml</i>	Non packed <input checked="" type="checkbox"/>
Stop date <input checked="" type="checkbox"/> Valid for duration of chart		Route <i>PO</i>	
OR Stop date	Additional instructions <i>50 microg/ml</i>	Frequency <i>daily</i>	
PBS/RPBS <input checked="" type="checkbox"/>	Streamlined authority code <i>36322</i>		
CTG <input type="checkbox"/>	Brand substitution not permitted <input checked="" type="checkbox"/>		
Prescriber signature and <i>Joseph Smith</i>		Date of prescribing <i>26/12/20</i>	

The prescriber **MUST** write legibly the dose, route, frequency and strength as well as the medicine name as indicated in the prescription box.

The prescriber **MUST** complete the streamlined authority code for medicines to be supplied as Authority Required STREAMLINED.

The prescriber **MUST** complete this box.

Nutritional supplements daily intake record

Month 1:		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																				
Date →		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	← Date
Start weight		initial																															
		initial																															

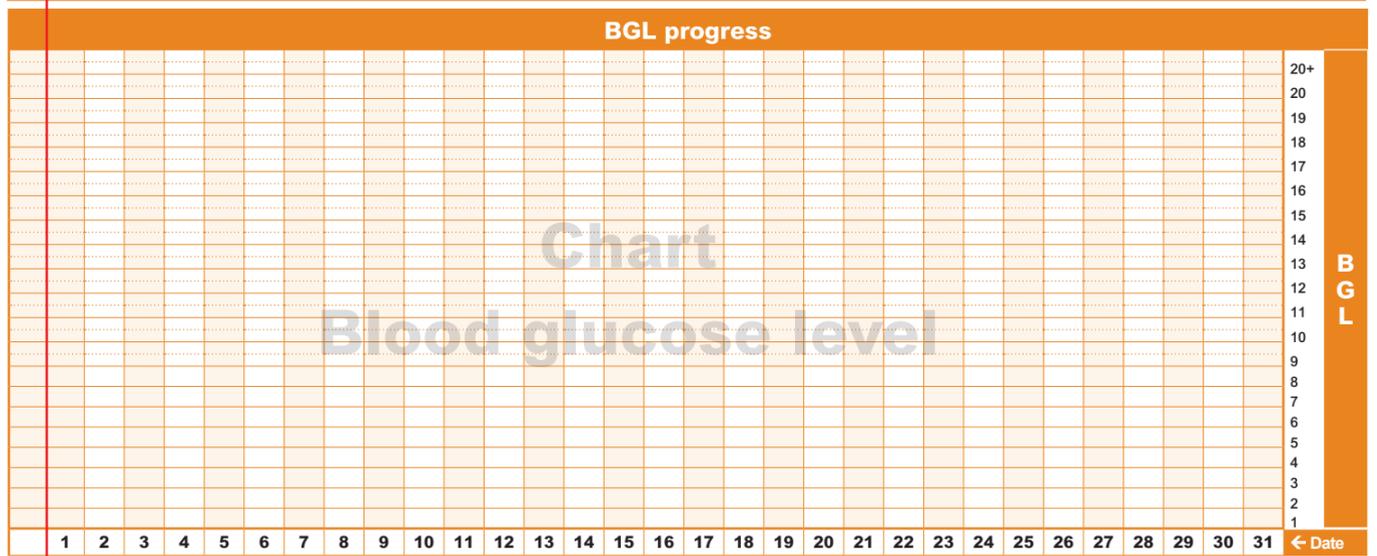
Month 2:		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																				
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Start weight		initial																															
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Month 3:		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																				
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		initial																															

Month 4:		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																				
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Start weight		initial																															
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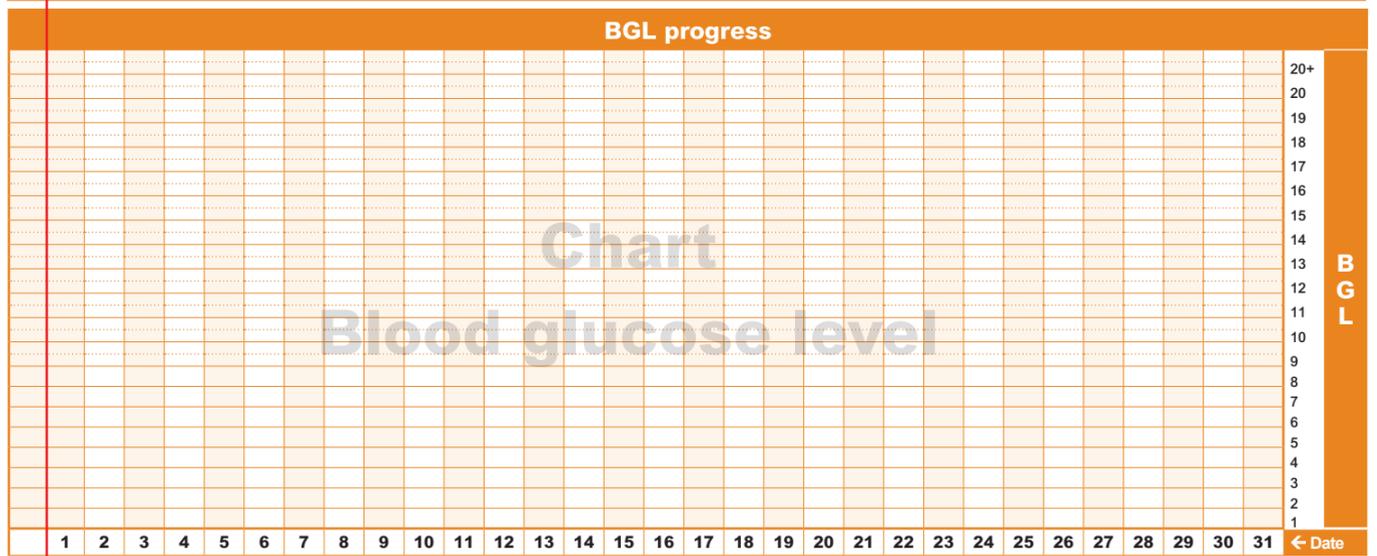
New chart required within 2 weeks

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Blood glucose level																																														BGL	
Blood glucose level																																															Time
Blood glucose level																																															BGL



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Blood glucose level																																											Time			
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Month 4																														

New chart required within 2 weeks page 10

Month 2:																	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
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Insulin administration																															Time
Insulin administration																															Dose
Insulin administration																															Initial 1
Insulin administration																															Initial 2
Insulin administration																															Time
Insulin administration																															Dose
Insulin administration																															Initial 1
Insulin administration																															Initial 2

page 43

Regular medicine **Month 1:** Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Start date ___/___/___ Stop date <input type="checkbox"/> Valid for duration of chart OR Stop date ___/___/___	4. Medicine/form/strength 4 Additional instructions	Dose	Date → Times ↓ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
		Route	
PBS/RPBS Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>		Frequency	Non packed
Prescriber signature and name Date of prescribing ___/___/___			

Start date ___/___/___ Stop date <input type="checkbox"/> Valid for duration of chart OR Stop date ___/___/___	5. Medicine/form/strength 5 Additional instructions	Dose	Date → Times ↓ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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PBS/RPBS Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>		Frequency	Non packed
Prescriber signature and name Date of prescribing ___/___/___			

Prescription 6 on next page

Month 1:		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec																		
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Insulin administration																															Initial 1
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Month 2:																														
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Dose prescribed																															
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Time																															
Initial 1																															
Initial 2																															

Variable dose

Month 3:																															
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Pathology result																															
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Variable dose

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Pathology result																															
Dose prescribed																															
Dose given																															
Time																															
Initial 1																															
Initial 2																															

Variable dose

New chart required within 2 weeks

Phone order

Medicine	Dose	Reason ordered	Date																
	Route		Additional instructions	Time															
	Frequency			Dose															
	Start date	Signature 1	Date																
Strength	Stop date	Signature 2	Date																
Prescriber name		Prescriber signature	Date																

Medicine	Dose	Reason ordered	Date																
	Route		Additional instructions	Time															
	Frequency			Dose															
	Start date	Signature 1	Date																
Strength	Stop date	Signature 2	Date																
Prescriber name		Prescriber signature	Date																

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Strength	Stop date	Signature 2	Date																
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Month 4																															

New chart required within 2 weeks page 18

Nurse initiated medicine

Medicine	Dose	Date																								
		Time																								
Indication	Route	Dose																								
		Initial																								
Date _/_/___	RN signature and name	Frequency																								
		Time																								
		Dose																								
		Initial																								
Medicine	Dose	Date																								
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Indication	Route	Dose																								
		Initial																								
Date _/_/___	RN signature and name	Frequency																								
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Medicine	Dose	Date																								
		Time																								
Indication	Route	Dose																								
		Initial																								
Date _/_/___	RN signature and name	Frequency																								
		Time																								
		Dose																								
		Initial																								



Short term medicine



			Month: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec																				
Start date _/_/	Medicine/form/strength	Dose	Date → Times ↓																				
		Route																					
Stop date _/_/	Additional instructions	Frequency																					
PBS/RPBS CTG <input type="checkbox"/>		Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Brand substitution not permitted <input type="checkbox"/>																				
Prescriber signature and name Date of prescribing _/_/																							

			Month: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec																				
Start date _/_/	Medicine/form/strength	Dose	Date → Times ↓																				
		Route																					
Stop date _/_/	Additional instructions	Frequency																					
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Month 3																														



Short term medicine

Month:			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Start date ___/___/___ Stop date ___/___/___	Medicine/form/strength _____ Additional instructions _____	Dose _____ Route _____ Frequency _____	Date → Times ↓											
PBS/RPBS <input type="checkbox"/> Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>		Prescriber signature and name Date of prescribing ___/___/___												

Month:			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Start date ___/___/___ Stop date ___/___/___	Medicine/form/strength _____ Additional instructions _____	Dose _____ Route _____ Frequency _____	Date → Times ↓											
PBS/RPBS <input type="checkbox"/> Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>		Prescriber signature and name Date of prescribing ___/___/___												



Short term medicine



			Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Start date ____/____/____	Medicine/form/strength _____ _____	Dose _____	<input type="checkbox"/> Non packed	Date → Times ↓											
Stop date ____/____/____	Additional instructions _____ _____	Route _____													
PBS/RPBS <input type="checkbox"/> Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prescriber signature and name _____														
CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>	Date of prescribing ____/____/____														

			Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Start date ____/____/____	Medicine/form/strength _____ _____	Dose _____	<input type="checkbox"/> Non packed	Date → Times ↓											
Stop date ____/____/____	Additional instructions _____ _____	Route _____													
PBS/RPBS <input type="checkbox"/> Streamlined authority code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prescriber signature and name _____														
CTG <input type="checkbox"/> Brand substitution not permitted <input type="checkbox"/>	Date of prescribing ____/____/____														

Month 3:																														
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec																														
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Month 3																														
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Month 3																														

Month 4:																	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Month 4																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Month 4																															

New chart required within 2 weeks



Regular medicine

Month 4:																	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Month 4																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Month 4																															

10. Medicine/form/strength
10

Start date ___/___/___
Stop date ___/___/___
 Valid for duration of chart
 OR
Stop date ___/___/___

Dose _____
Route _____
Frequency _____

Additional instructions _____

PBS/RPBS Streamlined authority code
 CTG Brand substitution not permitted

Prescriber signature and name _____
 Date of prescribing ___/___/___

Date →
Times ↓

Non packed

11. Medicine/form/strength
11

Start date ___/___/___
Stop date ___/___/___
 Valid for duration of chart
 OR
Stop date ___/___/___

Dose _____
Route _____
Frequency _____

Additional instructions _____

PBS/RPBS Streamlined authority code
 CTG Brand substitution not permitted

Prescriber signature and name _____
 Date of prescribing ___/___/___

Date →
Times ↓

Non packed

Check if consumer has another medication chart

New chart required within 2 weeks