APPENDIX A

PHARMACY REQUISITION FORM

OSPITAL NG PARAÑAQUE
PREMIER 101
REQUISITION FORM

PHARMACY DEPARTMENT

DATE:

NO.	DRUG DESCRIPTION	QTY	REMARKS

Requested by:	**Approved by:**
Received by:	

APPENDIX B

OSPITAL NG PARAÑAQUE

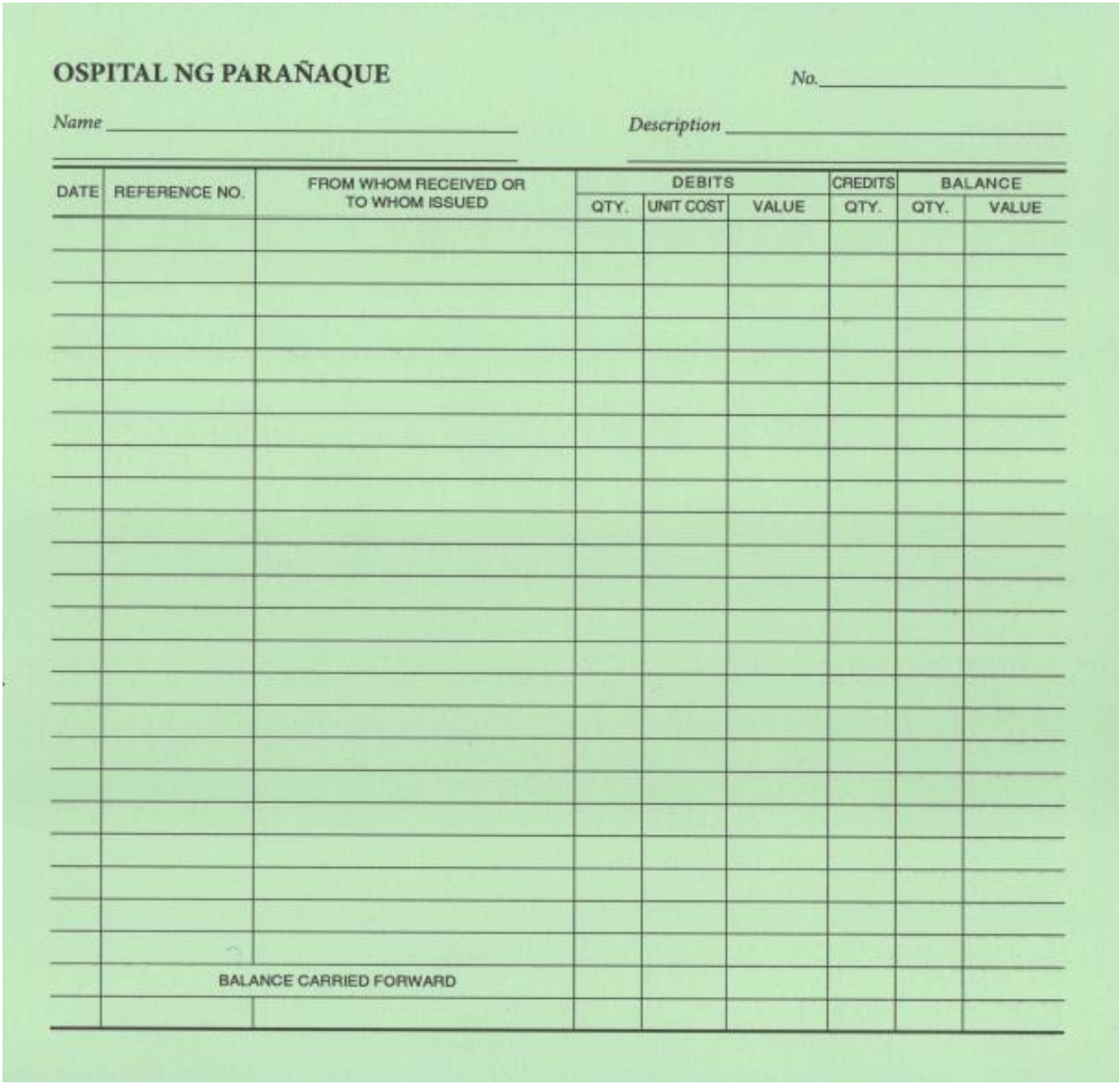
440 Quirino Avenue, La Huerta, Parañaque City
Tel: 825-4902 Telefax: 826-3034
Email: ospitalngparanaque@yahoo.com
PhilHealth Accredited

DISPENSING FORM FOR DONATED MEDICINES

NAME OF PATIENT	MEDICINE	QUANTITY	SIGNATURE	DATE

APPENDIX C

OFFICIAL STOCK CARD OF THE HOSPITAL



OSPITAL NG PARAÑAQUE

No. _____

Name _____ Description _____

DATE	REFERENCE NO.	FROM WHOM RECEIVED OR TO WHOM ISSUED	DEBITS			CREDITS	BALANCE	
			QTY.	UNIT COST	VALUE	QTY.	QTY.	VALUE
		BALANCE CARRIED FORWARD						

APPENDIX D

OFFICIAL PRESCRIPTION FORM OF THE HOSPITAL

OSPITAL NG PARANAQUE
440 QUIRINO AVE. LA HUERTAPARANAQUE CITY
PhilHealth Accredited

Patient' Name _____ Age_____ Sex _____ Date_____
Ward _____ Bed No. _____ OPD Clinic _____

Rx

Generic Name of Drug(s)	Dose and Frequency (for drugs only)	Qty.

Signatue: _____
Printed Name: _____
License No. _____
S2 License No. _____

APPENDIX E

OFFICIAL CHARGE TICKET OF THE HOSPITAL

OSPITAL NG PARANAQUE
440 QUIRINO AVE. LA HUERTAPARANAQUE CITY
CHARGE TICKET

Name: _____
Date: _____ Section:_____

PARTICULARS	QTY	U/P	AMOUNT

TOTAL_____

Prepared by:
_____

Noted by:
_____

APPENDIX F

GENERIC WHITE AND RED LABEL

OSPITAL NG PARANAQUE
QUIRINO AVE. LA HUERTA
PARANAQUE CITY

_____

Name of patient_____Date:_____

Rx

OSPITAL NG PARANAQUE
QUIRINO AVE. LA HUERTA
PARANAQUE CITY

_____

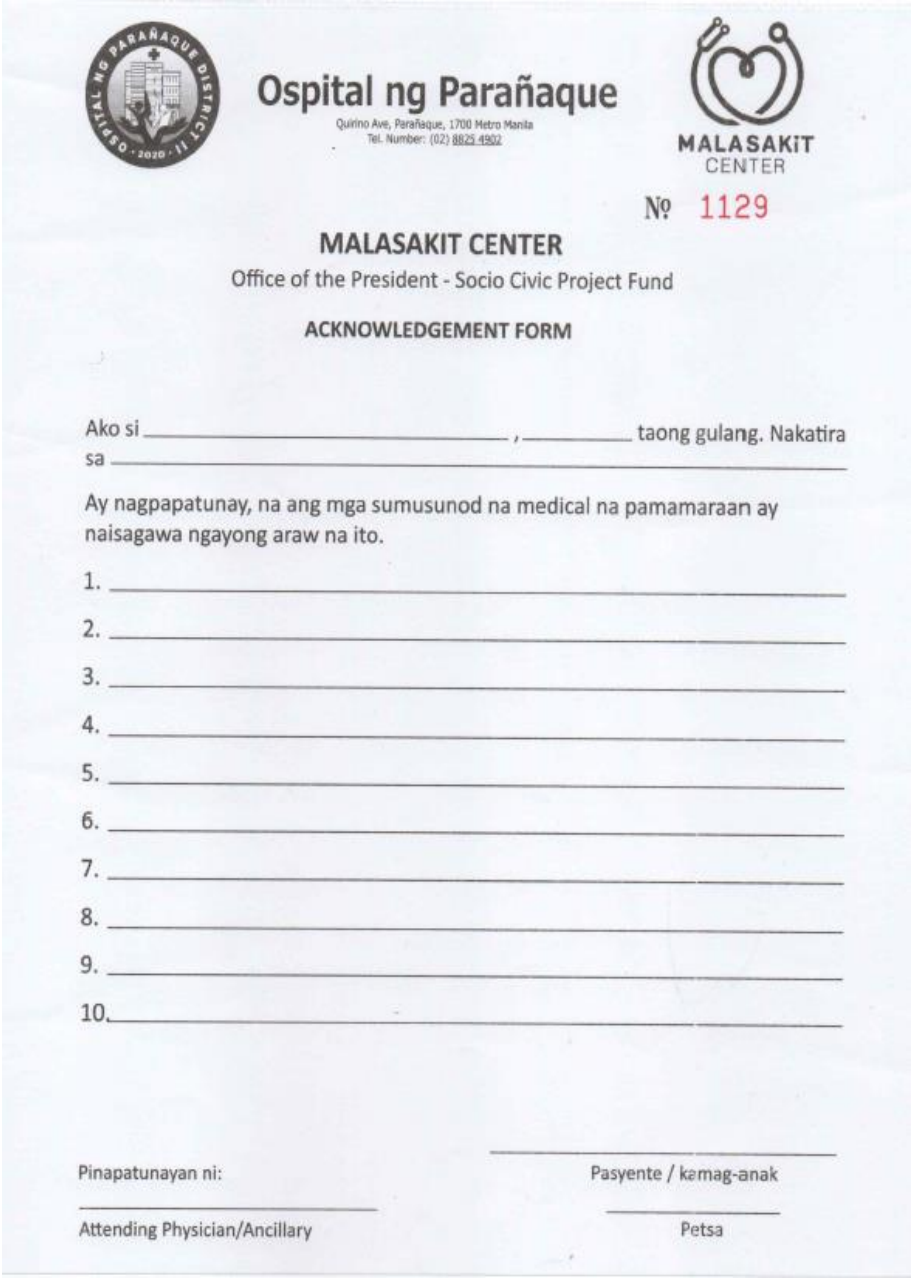
Name of patient_____Date:_____

Rx

FOR EXTERNAL USE ONLY

APPENDIX G

SOCIAL SERVICE/MALASAKIT CENTER
ACKNOWLEDGEMENT FORM



Ospital ng Parañaque
Quirino Ave, Parañaque, 1700 Metro Manila
Tel. Number: (02) 8825 4902

MALASAKIT CENTER

№ 1129

MALASAKIT CENTER
Office of the President - Socio Civic Project Fund

ACKNOWLEDGEMENT FORM

Ako si _____, _____ taong gulang. Nakatira sa _____

Ay nagpapatunay, na ang mga sumusunod na medical na pamamaraan ay naisagawa ngayong araw na ito.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

_____
Pinapatunayan ni: Pasyente / kamag-anak

_____ _____
Attending Physician/Ancillary Petsa

APPENDIX H

PDEA Local Order Permit Application (LOPA)

FM-CSVIrd-09

LOCAL ORDER PERMIT APPLICATION for Dangerous Drugs, its Preparation and Table 1 Controlled Chemical/s used in the manufacture of Dangerous Drugs Preparation/s or its Pharmaceutical Preparation/s

Date: _____

Request for approval to purchase/transfer the following Dangerous Drugs (DD) and/or their preparation/s (DDP) from
Name of Supplier / Source: _____
with business address at _____
Current S-License Number_____ Valid until_____

GENERIC NAME/ RAW MATERIAL/S	BRAND NAME	Dosage Strength	Dosage Form	QUANTITY ORDERED/ TO BE USED (e.g. pcs/bxs/kgs)	Packaging Presentation	Balance on Hand as of request date	Previous Approved LOP #
1.							
2							
3.							
4.							
5.							

ENCIRCLE INTENDED PURPOSE OF SUBJECT DD / DDP: Transfer to S3 / Transfer to S2 / Transfer to S6 / Manufacture / Destruction / Returned Stocks / Evaluation / Medical Mission / Donation / Surrender to PDEA Laboratory Service/ Transfer to Court / FDA Registration sample / Reference Standard / Others Transfer **(e.g. Transfer to - S4/S5I/S5C/S5D)**: _____.

Name and Signature of Authorized Pharmacist:_____ PRC No._____ Exp._____/PTR _____Dated____

Name of Entity: _____ Address: _____

Current S- License Number: _____ Valid Until _____

REMINDERS:

1. ONLY LEGIBLE AND COMPLETELY FILLED-OUT FORM WITH CORRECT DATA WILL BE PROCESSED.
2. ANY CHANGES/CORRECTION IN DATA PRIOR APPROVAL SHALL BE MADE & SIGNED BY THE AUTHORIZED PHARMACIST. (USE ONLY ONE SIGNATURE)
3. COORDINATION TO BE MADE WITH SUPPLIER ON STOCK AVALABILITY PRIOR TO LOP APPROVAL. SUPPLIER NOT TO DELIVER INSUFFICIENT QUANTITY ORDERED. NO ALTERATION ALLOWED ONCE APPROVED.
4. A REPRESENTATIVE IS ALLOWED TO TRANSACT UPON SUBMISSION OF AN AUTHORIZATION LETTER AND PHOTOCOPY OF VALID ID OF REPRESENTATTIVE.
5. TO SECURE AN APPROVED LOP PRIOR TRANSFER/ SURRENDER OF DANGEROUS DRUG TO PDEA LABORATORY SERVICE.

(APPLICANT'S COPY)

----------Please cut here ---------- Please cut here ---------- Please cut here----------

FM-CSVIrd-09

LOCAL ORDER PERMIT APPLICATION for Dangerous Drugs, its Preparation and Table 1 Controlled Chemical/s used in the manufacture of Dangerous Drugs Preparation/s or its Pharmaceutical Preparation/s

Date: _____

Request for approval to purchase/transfer the following Dangerous Drugs (DD) and/or their preparation/s (DDP) from
Name of Supplier / Source: _____
with business address at _____
Current S-License Number_____ Valid until_____

GENERIC NAME/ RAW MATERIAL/S	BRAND NAME	Dosage Strength	Dosage Form	QUANTITY ORDERED/ TO BE USED (e.g. pcs/bxs/kgs)	Packaging Presentation	Balance on Hand as of request date	Previous Approved LOP #
1.							
2							
3.							
4.							
5.							

ENCIRCLE INTENDED PURPOSE OF SUBJECT DD / DDP: Transfer to S3 / Transfer to S2 / Transfer to S6 / Manufacture / Destruction / Returned Stocks / Evaluation / Medical Mission / Donation / Surrender to PDEA Laboratory Service / Transfer to Court / FDA Registration sample / Reference Standard / Other Transfer **(e.g. Transfer to - S4/S5I/S5C/S5D)**: _____.

Name and Signature of Authorized Pharmacist:_____ PRC No._____ Exp._____/PTR _____Dated____

Name of Entity: _____ Address: _____

Current S- License Number: _____ Valid Until _____

(PDEA COPY)

_____
PRINTED NAME AND SIGNATURE OF RECEIVER
(AUTHORIZED PHARMACIST OR REPRESENTATIVE)

TIME	
RECEIVED	:_____
PROCESSED	:_____
APPROVED/PRINT	:_____
TOTAL TIME	:_____ mins.

APPENDIX I

Controlled Drugs Administration Sheet

Controlled Drugs Administration Sheet

RECORD OF DANGEROUS DRUG PREPARATION AND DRUG PREPARATIONS CONTAINING CONTROLLED CHEMICAL DISPENSED TO IN-PATIENTS (THROUGH FLOOR STOCK)

With Reference to Requisition No.: _____ Date: _____

Name of Controlled Drug Preparation: _____

Quantity: _____

Date of Adm	Time of Admin	Full Name of Patient	Patient/Hosp ID No.	Room/Bed No.	Name of Prescribing Doctor	S2 License No.	Physician's Signature	Name of Administering Nurse	PRC License No.	Nurse Signaure	Dose	Balance	Remarks

I hereby certify that the above information is true and correct: _____

Printed Name and Signature of Head Nurse

APPENDIX J

REQUISITION FOR DANGEROUS DRUG PREPARATION OR DRUG PREPARATION CONTAINING CONTROLLED CHEMICAL FOR IN-PATIENT USE

OSPITAL NG PARAÑAQUE

REQUISITION FOR DANGEROUS DRUG PREPARATION OR DRUG PREPARATION CONTAINING CONTROLLED CHEMICAL FOR IN-PATIENT USE

Requisition No.: _____ Date: _____

To: The Chief Pharmacist

Request for (initial/replenishment) of emergency /floor stocks of the controlled drug name hereunder:

Name of controlled drug,dosage strength and form	Quantity	Ward/Unit where needed

The undersigned undertakes to submit the corresponding Administration sheet to fully account the disposition of the requesed controlled drug and to facilitate replenishment of stock. Further, take full responsibility and accountability on subject controlled drug.

_____
Printed Name and Signature of Nurse-in-charge

Conforme:

_____
Printed Name and Signature of Physician on duty

****

This portion to be filled out by the Pharmacist:

[ ] APPROVED [ ] DISAPPROVED

State Reason: _____

_____
Printed Name, Signature of Dispensing Pharmacist/Date

****

_____
Printed Name,Signature of Receiving Nurse/Date

APPENDIX K

ADVERSE DRUG REACTION FORM

National Pharmacovigilance Center
"Saving Lives Through Vigilant Reporting"
Send completed form to: ADR Unit, FDA, Civic Drive, Filinvest Estate, Alabang, Muntinlupa ,1781.
Or fax to: (02) 807-85-11, c/o The ADR Unit. **Send sample, if any, of suspect drug for analysis.**
Website: www.fda.gov.ph

SUSPECTED ADVERSE REACTIONS FORM v 5 (4/2012)
"Saving Lives Through Vigilant Reporting"
FIELDS MUST BE COMPLETED.

For FDA use only *All reports are confidential.*
AER No. 2012-0001
Date received: _____

PATIENT'S PARTICULARS

*Patient's Name or Initials_____ * Sex: ☐ Male ☐ Female Weight _____Kg Height (cm) _____
Address or Contact Number: _____ *Age_____ Date of Birth (mm/dd/yr)_____
Medical History/Admitting Diagnosis: _____ Ethnic group: ☐ Filipino ☐ Chinese ☐ Caucasian
Any Known Allergy: ☐ No ☐ Yes, Specify:_____ Pregnancy Status: ___ No
Hospital/facility , if admitted:_____ ___ Yes (1st, 2nd, 3rd trimester)

***DETAILS OF THE ADVERSE REACTION**

Date of onset:_____; ___am, ___pm | Do you consider the reaction to be serious? ☐ Yes, if yes indicate why: ☐ No

Describe the reaction, including pertinent laboratory data:

☐ Patient died due to reaction
☐ Involved or prolonged in-patient hospitalization
☐ Life threatening
☐ Involved persistent or significant disability
☐ Congenital anomaly in the newborn
☐ Other outcome, please give details:

Can this be due to Medication Error? ☐ No
☐ Yes, if yes, which type:
___Prescribing
___Transcription
___Dispensing
Administration

Can the adverse reaction be due to :

1. **Product quality defect** ___No ___**Yes, Specify, encircle:** color change ; caking; powdering ; counterfeit; odor change; defective container; contaminants; separation of components; undissolved suspension/powder
2. **Therapeutic failure:** ___No ___**Yes, Specify, encircle:** antimicrobial resistance, drug interaction, poor compliance, counterfeit, expired; improper storage; under-dosing, inappropriate medication; inappropriate route of administration; excipients/preservatives

*Suspected drug product(s) Indicate brand name	Daily Dose	Route	Date started	Date stopped	Reason (s) for using the product (Indication)	Manufacturer and Batch/Lot #

List all other drug/s taken at the same time and/ or 3 months before. If none, check box. ☐ *No Other drug/s taken*

Brand name of the drug	Daily Dose	Route	Date started	Date stopped	Reason/s for using the drug	Manufacturer and Batch & Lot No.

***MANAGEMENT OF ADVERSE REACTION**

Was treatment given? ☐ **No** ☐ **Yes** (If yes, please specify): _____
Outcome:
☐ Recovered (Date of recovery):_____ ☐ Unrecovered **Other diseases**: _____liver _____renal _____HPN
☐ Fatal (Date of death):_____ ☐ Unknown _____ Diabetes _____CVS ____Endocrine ____Cancer
Sequela/e: (any permanent complications or injuries as a result of the ADR) **Re-challenge?** ☐ **Yes Result**_____
☐ **Yes (Please specify)**_____ ☐ **No** ☐ **Unknown** ☐ **No**

*** REPORTER'S PARTICULARS**

*Printed Name of Reporter: _____
Signature of reporter: _____
Date reported (mm/dd/yr): _____

*Contact no:_____
Email address: _____
*Profession: __MD ___RPh ___RN___Patient ___Dentist ___other
*Facility: ___Clinic ____Trial site _____Other

National Pharmacovigilance Center
"Saving Lives Through Vigilant Reporting"
Send completed form to: ADR Unit, FDA, Civic Drive, Filinvest Estate, Alabang, Muntinlupa ,1781.
Or fax to: (02) 807-85-11, c/o The ADR Unit. **Send sample, if any, of suspect drug for analysis.**
Website: www.fda.gov.ph

APPENDIX L

MEDICATION INCIDENT REPORTING FORM

OSPITAL NG PARAÑAQUE
440 Quirino Avenue, La Huerta, Parañaque City
Tel: 825-4902 Telefax: 826-3034
Email: ospitalngparanaque@yahoo.com
PhilHealth Accredited

MEDICATION INCIDENT REPORTING FORM

Ward/ Department: _____ Incident Date: _____
Position of Reporting Staff: _____ Incident Time: _____

A. Description of the Incident:
(What, When, Where, How and Who)

_____
_____
_____
_____
_____
_____
_____
_____
_____

B. Rank of Staff who made the mistake:

Medical Staff	Nursing Staff	Pharmacy Staff	Others (Please Specify)
_____	_____	_____	_____
_____	_____	_____	_____

C. Type Of Error (Please check the Appropriate Box)

- ☐ 1. Wrong patient
- ☐ 2. Wrong patient record
- ☐ 3.Wrong date : Prescribed date_____ Date actually administered _____
- ☐ 4. Wrong time : Prescribed time_____ Time actually administered _____
- ☐ 5. Wrong dose: Prescribed dose_____ Dose actually dispensed/administered_____
- ☐ 6. Extra dose given
- ☐ 7. Wrong route: Prescribed route_____ Route actually dispensed/administered_____
- ☐ 8. Wrong drug: Drug prescribed_____
  Drug actually dispensed/administered_____
- ☐ 9. Into the wrong solution:
  Solution prescribed _____ Solution actually used _____
- ☐ 10. Wrong I.V. Rate: Rate prescribed_____
  Rate actually administered _____
- ☐ 11. Right route but wrong mode of administration
  (e.g.Bolus injection instead of into infusion fluid)
  Prescribed mode_____ Mode actually administered_____
- ☐ 12. Expired stock dispensed/administered.
  Expiry date of drug & Batch # _____
- ☐ 13. Omission
- ☐ 14. Others (Please specify) _____

APPENDIX M

PHARMACY MONITORING CHART FOR
COLD CHAIN MANAGEMENT

DAILY MONITORING CHART FOR COLD CHAIN MANAGEMENT		
DATE	TEMPERATURE	STAFF ON DUTY