Standard Dosage Timing:
BD 8 am - 8 pm / 10 am - 10 pm, **TDS** 6 am - 2 pm - 10 pm, 8am - 4pm - 12 midnight, **QDS** 6 am - 12 Noon - 6 pm - 12 midnight

ANTIMICROBIALS:

Filled by Doctors Only				Filled by Nursing Staff									

Drug 1

		Standard Time	Date ____		Date 4|10|24		Date 5|10|24		Date ____		Date ____	
			Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by

Drug Name: INJ. ACTACREZ
Generic Name: CEFTAZIDIME P TAZOBACTUM

Dose	Route	Frequency					Jyotsna 8					
2.25gm	IV	1-0-1	8AM									

Special Instructions:

Start Date & Time	Consultant Name	Doctor's Sign. & ID					Siddhi 2:10PM					
4/3 1pm	Dr KR		8pm				Jyotsna 8AM		8:15 8pm			

Stop Date & Time | Consultant Name | Doctor's Sign. & ID

Drug 2

		Standard Time	Date ____		Date ____		Date 5|10|		Date ____		Date ____	
			Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by

Drug Name: INJ AMIKACIN
Generic Name: AMIKACIN.

Dose	Route	Frequency	10 0m									
250 MG	IV	1-0-1										

Special Instructions:

Start Date & Time	Consultant Name	Doctor's Sign. & ID					8AM					
5 5:30pm	Raj	DI687	10 pm									

Stop Date & Time | Consultant Name | Doctor's Sign. & ID

Drug 3

		Standard Time	Date ____		Date ____		Date ____		Date ____		Date ____	
			Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by

Drug Name:
Generic Name:

Dose	Route	Frequency

Special Instructions:

Start Date & Time | Consultant Name | Doctor's Sign. & ID

Stop Date & Time | Consultant Name | Doctor's Sign. & ID

Drug 4

		Standard Time	Date ____		Date ____		Date ____		Date ____		Date ____	
			Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by

Drug Name:
Generic Name:

Dose	Route	Frequency

Special Instructions:

Start Date & Time | Consultant Name | Doctor's Sign. & ID

Stop Date & Time | Consultant Name | Doctor's Sign. & ID

Drug 5

		Standard Time	Date ____		Date ____		Date ____		Date ____		Date ____	
			Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by	Time & Given by	Checked by

Drug Name:
Generic Name:

Dose	Route	Frequency

Special Instructions:

Start Date & Time | Consultant Name | Doctor's Sign. & ID

Stop Date & Time | Consultant Name | Doctor's Sign. & ID

MAR - Medication appropriateness review, CPT - Clinical Pharmacology Team   .. 2 ..