Affix patient identification label here

URN:
Family name:
Given names:
Address:

Not a valid prescription unless identifiers present

Date of birth: Sex: M◯ F◯

First prescriber to print patient name and check label correct: ....

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20........

Date	Medicine (print generic name)		
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	
Indication		Pharmacy	
Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
Sign													

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

Date	Medicine (print generic name)		
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	
Indication		Pharmacy	
Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
Sign													

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

Date	Medicine (print generic name)		
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	
Indication		Pharmacy	
Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
Sign													

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

Date	Medicine (print generic name)		
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	
Indication		Pharmacy	
Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
Sign													

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

Date	Medicine (print generic name)		
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Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
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Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....

Date	Medicine (print generic name)		
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Date													
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Dose													
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Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....

Date	Medicine (print generic name)		
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	
Indication		Pharmacy	
Prescriber signature	Print your name		Contact

Date													
Time													
Dose													
Route													
Sign													

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

Prescriber's signature: .... Print your name: .... Date: ....

Pharmacist: .... Date: ....

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Cut off section

Medication chart number .... **of** ....

Facility/service: ....

Ward/unit: ....

Additional charts
☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other
☐ Palliative care ☐ Chemotherapy ☐ IV heparin

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) Signature	Print your name	Given by	Time given	Pharmacy

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

Date time	Medicine (print generic name)	Route	**Dose**	Frequency	Check initials		Prescriber name	Pres. sign	Date	Record of administration			
					N1	N2				Time / given by	Time / given by	Time / given by	Time / given by

Medicines taken prior to presentation to hospital

(Prescribed, 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:

NIMC (acute)

Cut off section

Attach ADR sticker

Allergies and adverse drug reactions (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Affix patient identification label here and overleaf

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** M ○ ○

First prescriber to print patient name and check label correct: .....

Weight (kg): ..... Height (cm): .....

Regular medicines

Year 20 ..... **Date and month** →

Variable dose medicine

Date | Medicine (print generic name)

Route | Frequency

Prescriber to enter dose times and individual dose

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Drug level

Time level taken

Dose

Prescriber

Time to be given: .....

Time given

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Date:

VTE risk assessed: Yes ☐ **Prophylaxis not required** ☐ **Contraindicated** ☐ Signature: Date:

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

VTE prophylaxis

Prescriber signature | Print your name | Contact

Mechanical prophylaxis

Prescriber/NI signature | Print your name | Contact

AM check

PM check

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Pharmacist:

Date | **Warfarin** | **Marevan / Coumadin** select brand

Route | Prescriber to enter individual doses | Target INR Range

Indication | Pharmacy

Prescriber signature | Print your name | Contact

INR Result

Dose mg mg mg mg mg mg mg mg mg mg mg

Prescriber

1600 Initial 1

Initial 2

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Date:

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Tick if slow release

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Print your name:

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Prescriber's signature:

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Pharmaceutical review:

Recommended administration times

Guidelines only

Morning	Mane	0800				
Night	Nocte				1800 or 2000	
Twice a day	BD	0800		2000		
Three times a day	TDS	0800	1400	2000		
Regular 6 hourly	6 hrly	0600	1200	1800	2400	
Regular 8 hourly	8 hrly	0600	1400	2200		
Four times a day	QID	0600	1200	1800	2200	

SR = Sustained, modified or controlled release formulation.

Tick if slow release

If scored tablet, then half can be given.

Dose must be swallowed without crushing.

Warfarin education record

Patient educated by: .....

Sign: .....

Date: .....

Given warfarin book: .....

Sign: .....

Date: .....

Reason for not administering

Codes MUST be circled

Absent	A
Fasting	F
Refused – notify prescriber	R
Vomiting	V
On leave	L
Not available – obtain supply or contact prescriber	N
Withheld – enter reason in clinical record	W
Self administered	S

Regular medicines

Year 20 ..... **Date and month** →

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ..... days Qty: .....

Date:

Pharmacist:

Print your name:

Prescriber's signature:

Pharmaceutical review: