

Attach ADR Sticker

FAMILY NAME BUTTERWORTH MRN 0411817
 GIVEN NAME WENDY MALE FEMALE
 D.O.B. 15/03/46 M.O. FRANCESCA
 ADDRESS
 LOCATION VASCULAR WARD

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
 Nil known Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
 First Prescriber to Print Patient Name and Check Label Correct: Weight(kg):..... Height(cm):.....

REGULAR MEDICATIONS

YEAR 20 18 DATE & MONTH → 11/6 12/6 13/6 14/6

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Drug level	Time level taken	Dose	Prescriber	Time to be given:	Time given & Sign	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:
11/6	Clexane			2000	Goldburg					

VTE risk assessed: Yes Prophylaxis not required Contraindicated Signature _____ Date _____

Date 11/6 Medication (Print Generic Name) Clexane
 Route Dose Frequency & NOW Enter Times slc 40mg Nocte. 2000 (W) MS/RS MS/RS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

VTE Prophylaxis

Mechanical Prophylaxis Teds. (Left leg). AM → MG MG KS
 Prescriber/NI Signature Print Your Name Contact Goldburg
 PM MS MS MS

WARFARIN (Marevan/Coumadin)

Date 11/6 Medication (Print Generic Name) WARFARIN (Marevan/Coumadin) select brand
 Route Dose Frequency & NOW Enter Times 1600 (Nurse 1)
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

DOCTORS MUST ENTER administration times

Date 11/6 Medication (Print Generic Name) Telmisartan
 Route Dose Frequency & NOW Enter Times PO 40mg mane. 0800 → (W) MG KS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

Date 11/6 Medication (Print Generic Name) Atorvastatin
 Route Dose Frequency & NOW Enter Times PO 40mg nocte. 2000 MS MS MS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

Date 11/6 Medication (Print Generic Name) Digoxin
 Route Dose Frequency & NOW Enter Times PO 62.5 microg nocte. 2000 MS MS MS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY

Time	Frequency	0800	1400	1800	2000	2200
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	

WARFARIN EDUCATION RECORD

Patient Educated by: _____
 Sign: _____
 Date: _____
 Given Warfarin Book: _____
 Sign: _____
 Date: _____

SR = Sustained, modified or controlled release formulation.
 If scored tablet, then half can be given.
 Dose must be swallowed without crushing.

- REASON FOR NURSE NOT ADMINISTERING**
 Codes MUST be circled
- Absent (A)
 - Fasting (F)
 - Refused - notify Dr (R)
 - Vomiting (V)
 - On leave (L)
 - Not available - obtain supply or contact Dr (N)
 - Withheld - enter reason in clinical record (W)
 - Self Administered (S)

REGULAR MEDICATIONS

YEAR 20 18 DATE & MONTH → 11/6 12/6 13/6 14/6

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Dose	Frequency & NOW Enter Times	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:
11/6	Metformin XR	2000	MS MS MS			
11/6	Pantoprazole	40mg	mane 0800 → MG MG KS			

Date 11/6 Medication (Print Generic Name) Metformin XR
 Route Dose Frequency & NOW Enter Times PO 2000 MS MS MS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

Date 11/6 Medication (Print Generic Name) Pantoprazole
 Route Dose Frequency & NOW Enter Times PO 40mg mane 0800 → MG MG KS
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact Goldburg

Date 11/6 Medication (Print Generic Name) _____
 Route Dose Frequency & NOW Enter Times _____
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact _____

Date 11/6 Medication (Print Generic Name) _____
 Route Dose Frequency & NOW Enter Times _____
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact _____

Date 11/6 Medication (Print Generic Name) _____
 Route Dose Frequency & NOW Enter Times _____
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact _____

Date 11/6 Medication (Print Generic Name) _____
 Route Dose Frequency & NOW Enter Times _____
 Indication Pharmacy
 Prescriber Signature Print Your Name Contact _____

Pharmaceutical Review: _____
 Check if patient has another Medication Chart

SMR130001
 Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING
 NH606207 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended 2014

NOT A VALID ORDER UNLESS LEGIBLE

