Attach ADR Sticker

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

Drug (or other)	Reaction/Type/Date	Initials

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

FAMILY NAME CARTER	MRN 2811196
GIVEN NAME HELEN	☐ MALE ☒ FEMALE
D.O.B. 30 / 09 / 31	M.O. EMERGENCY DR.
ADDRESS	
LOCATION EMERGENCY DEPARTMENT	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber to Print Patient Name and Check Label Correct: .... Weight(kg):............ Height(cm):............

NO PRESCRIPTION UNLESS IDENTIFIERS PRESENT

SMR130001

REGULAR MEDICATIONS

YEAR 20 18 DATE & MONTH →

VARIABLE DOSE MEDICATION

Date | Medication (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 & Sign

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

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

Date | Medication (Print Generic Name)
Route | Frequency & NOW Enter Times
Indication — *VTE Prophylaxis* | Pharmacy
Prescriber Signature | Print Your Name | Contact
Mechanical Prophylaxis — AM
Prescriber/NI Signature | Print Your Name | Contact — PM

Date | **WARFARIN** (Marevan/Coumadin) select brand — INR Result
Route | Prescriber to enter individual doses | Target INR Range — **Dose** mg mg mg mg mg mg mg mg
Indication | Pharmacy — Prescriber
Prescriber Signature | Print Your Name | Contact — *1600* (Nurse 1) — Nurse 2

DOCTORS MUST ENTER administration times

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency & NOW Enter Times
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

(repeated for 3 medication entries)

Pharmaceutical Review:

Check if patient has another Medication Chart

Date: Pharmacist: Date: Contact: Print Name: Prescriber's Signature:

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

WARFARIN EDUCATION RECORD
Patient Educated by:............
Sign:............
Date:............
Given Warfarin Book:............
Sign:............
Date:............

Tick if Slow Release — 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 .... DATE & MONTH →

DOCTORS MUST ENTER administration times

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency & NOW Enter Times
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact
Continue on discharge? Yes / No — Dispense? Yes / No — Duration: ...... days Qty: ......

(repeated for 6 medication entries)

Pharmaceutical Review:

Check if patient has another Medication Chart

Date: Pharmacist: Date: Contact: Print Name: Prescriber's Signature:

NOT A VALID ORDER UNLESS LEGIBLE

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

NSW GOVERNMENT | Health

MEDICATION Chart No. ______ **of** ______

Facility/Service: ____________________

Ward/Unit: ....

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Other
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Print Your Name	Given by	Time Given	Pharmacy
4/6/18	PARACETAMOL	PO	1g	STAT	GIBSON (RN)	CS	PG / CS	1000	

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1 / Nr 2	Dr Name	Dr Sign.	Date	RECORD OF ADMINISTRATION 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 medications brought in? ☐ Y ☐ N Administration Aid (Specify) ....

Medication	Dose & Frequency	Duration	Medication	Dose & Frequency	Duration

GP: Community Pharmacy:

Documented by: (Sign) (Date) Medicines usually administered by:

Check if patient has another Medication Chart

MEDICATION CHART (MR71)

SMR130.001

NOT A VALID ORDER UNLESS LEGIBLE

WP09_S1_CM13_MEDS

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20 18

FAMILY NAME	CARTER	MRN 2811196
GIVEN NAME	HELEN	☐ MALE ☒ FEMALE
D.O.B.	30 / 09 / 31	M.O. EMERGENCY DR.
ADDRESS		
LOCATION	EMERGENCY DEPARTMENT	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber **to Print Patient Name and Check Label Correct:** ....

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Date	Medication (Print Generic Name)			Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication		Pharmacy		Dose
				Route
Prescriber Signature	Print Your Name	Contact		Sign

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

Pharmacist .... Date: .... Contact: .... Print Name: .... Prescriber's Signature: ....

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001

Check if patient has another Medication Chart