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
PETHIDINE	RASH	
NORSPAN	NAUSEA	

Sign: [signature] Print: C. WO Date: 4/6

FAMILY NAME	CARTER	MRN	281196
GIVEN NAME	HELEN	☐ MALE	☒ FEMALE
D.O.B.	30 / 09 / 31	M.O.	DAVID ROHR
ADDRESS			
LOCATION	SURGICAL		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

MEDICAL STUDENT USE ONLY
NOT FOR ADMINISTRATION

SMR130001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REGULAR MEDICATIONS

YEAR 20 18 — DATE & MONTH → 4/6, 5/6, 6/6, 7/6

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name) | Drug level | Time level taken
Route | Frequency | Dose
Prescriber to enter dose times and individual dose | Prescriber
Indication | Pharmacy | Time to be given:
Prescriber Signature | Print Your Name | Contact | Time given & Sign

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

Field	Entry	Time	4/6	5/6	6/6
Date	4/6	0800	JH/RS	JH/RS	JH/RS
Medication	CLEXANE				
Route	S/C				
Dose	40mg				
Frequency & NOW Enter Times	MANE				
Indication	*VTE Prophylaxis*				
Prescriber Signature / Print Your Name	[signature] / C. WO				

Mechanical Prophylaxis — AM / PM
Prescriber/NI Signature | Print Your Name | Contact

WARFARIN (Marevan/Coumadin) select brand

Date | Route | Prescriber to enter individual doses | Target INR Range | Indication | Pharmacy | Prescriber Signature | Print Your Name | Contact
INR Result | Dose (mg) | Prescriber | 1600 (Nurse 1) | Nurse 2

DOCTORS MUST ENTER administration times

Date	Medication	Route	Dose	Frequency	Prescriber / Print Name	Time	4/6	5/6	6/6	7/6	…
4/6	FENTANYL 12MCG/HR	TOP	1	Q3 DAILY	[signature] / C WO	0800	→ X	JH/RS	X	X	… X X
						PATCH OFF		JH/RS			
4/6	PARACETAMOL	PO	1g	QID	[signature] / C. WO	0600	→ JH	JH	JH		
						1200	→ JH	JH			
						1800	HR	TW	TW		
						2200	LH	LH	DR		
4/6	ISOSORBIDE MONONITRATE	PO	60mg	MANE	[signature] / C. WO	0800	→ JH	JH	JH		

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

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

Check if patient has another Medication Chart

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 18 — DATE & MONTH → 4/6, 5/6, 6/6, 7/6

DOCTORS MUST ENTER administration times

Date	Medication	Route	Dose	Frequency	Indication	Prescriber / Print Name	Time	4/6	5/6	6/6	7/6	…
4/6	HYDRALAZINE	PO	12.5mg	MANE		[signature] / C. WO	0800	→	JH	JH	JH	
4/6	CLOPIDOGREL	PO	75mg	MANE		[signature] / C. WO	0800	→	(W)	(W)	JH	
4/6	FAMOTIDINE	PO	40mg	MANE		[signature] / C. WO	0800	→	JH	JH	JH	
4/6	ATORVASTATIN	PO	40mg	NOCTE		[signature] / C. WO	2000	HR	TW	TW		
4/6	PANTOPRAZOLE	PO	40mg	MANE		[signature] / C. WO	0800	→	JH	JH	JH	
4/6	CEPHAZOLIN	IV	1g	TDS.	POST OP.	[signature] / C. WO	0600	→	LH/GM	X	X	X X X X X
							1400	→	JH/RS	X	X	X X X X
							2200	LH/GM	X	X	X	X X X X

Tick if Slow Release — Continue on discharge? Yes / No — Dispense? Yes / No — Duration: ... days Qty:

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

Check if patient has another Medication Chart

NOT A VALID ORDER UNLESS LEGIBLE

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NSW GOVERNMENT | Health

Facility/Service: ____________________

Ward/Unit: ....

MEDICATION Chart No. 1 of 2

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)	GS	PG/LS	1000	
4/6	MORPHINE	IV	5mg	STAT	[signature]	C.WO	PG/LS	1100	
4/6	MORPHINE	IV	5mg	STAT	[signature]	C.WO	PG/LS	1330	
4/6	CEPHAZOLIN	IV	2g	STAT	[signature]	C.WO	RH/DS	1600	

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

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20 18

FAMILY NAME	CARTER	MRN	281196
GIVEN NAME	HELEN	☐ MALE	☒ FEMALE
D.O.B.	30/09/31	M.O.	DAVID ROHR
ADDRESS			
LOCATION	SURGICAL.		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Date	Medication (Print Generic Name)	Route	Dose & Hourly Frequency PRN	Max PRN dose/24 hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
4/6	NITROLINGUAL SPRAY	SL	ī SPRAY Q5MIN		CHEST PAIN		[signature]	C.WO	

Date	7/6	7/6
Time	0950	0955
Dose	ī	ī
Route	SL	SL
Sign	JH/RS	JH/RS

Date	Medication (Print Generic Name)	Route	Dose & Hourly Frequency PRN	Max PRN dose/24 hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
4/6	ENDONE	PO	5-10mg Q4H	40mg	PAIN		[signature]	C.WO	

Date	4/6	5/6	5/6	5/6	6/6	6/6	6/6	7/6
Time	2200	0600	1430	2115	0400	1315	2200	0700
Dose	10mg	10mg	10mg	5mg	10mg	10mg	5mg	5mg
Route	PO	PO	PO	PO	PO	PO	PO	PO
Sign	LH/GM	LH/GM	JH/RS	TW/EL	LH/GM	JH/RS	DR/BT	JH/RS

Date	Medication (Print Generic Name)	Route	Dose & Hourly Frequency PRN	Max PRN dose/24 hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
4/6	ONDANSETRON	IV/SL	4-8mg Q4H	24mg	N + V		[signature]	C.WO	

Date	4/6	5/6
Time	2300	1330
Dose	8mg	4mg
Route	IV	IV
Sign	LH/GM	JH/RS

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

(Each entry: Date / Time / Dose / Route / Sign administration rows; Continue on discharge? Yes / No; Dispense? Yes / No; Duration ....days/Qty; Pharmacist; Date; Contact; Print Name; Prescriber's Signature)

Check if patient has another Medication Chart

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001

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
PETHIDINE	RASH	
NORSPAN	NAUSEA	

Sign: [signature] Print: C. WO Date: 4/6

FAMILY NAME: CARTER	MRN: 2811196
GIVEN NAME: HELEN	☐ MALE ☒ FEMALE
D.O.B. 30 / 09 / 31	M.O. DAVID ROHR
ADDRESS	
LOCATION: SURGICAL.	

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 → 4/6, 5/6, 6/6, 7/6

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name) | Drug level | Time level taken
Route | Frequency — Prescriber to enter dose times and individual dose | **Dose** | Prescriber
Indication | Pharmacy | Time to be given:
Prescriber Signature | Print Your Name | Contact | 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 | Dose | 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)

DOCTORS MUST ENTER administration times

Nurse 2

Field	Entry	Time	4/6	5/6	6/6	7/6
Date	4/6					
Medication (Print Generic Name)	TARGIN 20/10 mg	0800	→	JH/RS	JH/RS	JH/RS
Route / Dose / Frequency & NOW Enter Times	PO / 1 / BD					
Indication	POST OP PAIN	2000	HR/CM	TW/EG	TW/EG	
Prescriber Signature / Print Your Name / Contact	[signature] / C. WO					

Tick if Slow Release ☐

Field	Entry	Time	4/6	5/6	6/6	7/6
Date	4/6					
Medication (Print Generic Name)	COLOXYL + SENNA	0800	→	JH	JH	JH
Route / Dose / Frequency & NOW Enter Times	PO / 2 / BD					
Indication	CONSTIPATION	2000	HR	TW	TW	
Prescriber Signature / Print Your Name / Contact	[signature] / C. WO					

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:

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

Pharmaceutical Review:
Check if patient has another Medication Chart

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

Reason	Code
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:

(blank medication entry repeated 6 times)

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

NOT VALID ORDER UNLESS LEGIBLE

Pharmaceutical Review:
Check if patient has another Medication Chart

SMR130001
Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING
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NSW GOVERNMENT | Health

Facility/Service: ____________________

Ward/Unit: ....

MEDICATION Chart No. 2 **of** 2

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	Prescriber/Nurse Initiator (NI) Print Your Name	Given by	Time Given	Pharmacy

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

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.	DAVID ROHR
ADDRESS			
LOCATION	SURGICAL .		

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: ....

Check if patient has another Medication Chart

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001