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 [signature] Print M COLLINS Date 30/09

Affix patient identification label here and overleaf

URN: NO XXXXX

Family name: FITZPATRICK

Given names: HENRY

Address:

Date of birth: 14/09/38 Sex: M☒ F☐

First prescriber to print patient name and check label correct: HENRY FITZPATRICK

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

Regular medicines

Year 20 ..... Date and month →

Variable dose medicine

Date | Medicine (print generic name) | Drug level

Route | Frequency | Time level taken

Prescriber to enter dose times and individual dose | **Dose**

Indication | Pharmacy | Prescriber | Continue on discharge? Yes / No | Dispense? Yes / No | Duration: ..... days Qty: .....

Prescriber signature | Print your name | Contact | Time to be given: ..... | Time given | Date: | Pharmacist:

VTE risk assessed: Yes ☐ Prophylaxis not required ☒ Contraindicated ☐ Signature [signature] 30/9

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: ..... | Date: | Print your name:

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's signature:

PRESCRIBER MUST ENTER administration times

Date 30/9 | Medicine (print generic name) METFORMIN | Tick if slow release

Route PO | Dose 800mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

Date 30/9 | Medicine (print generic name) ATORVASTATIN | Tick if slow release

Route PO | Dose 20mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

Date 30/9 | Medicine (print generic name) RAMIORIL | Tick if slow release

Route PO | Dose 10mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

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

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.

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 30/9 | Medicine (print generic name) ASPIRIN | Tick if slow release

Route PO | Dose 100mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

Date 30/9 | Medicine (print generic name) METOPROLOL | Tick if slow release ☑

Route PO | Dose 12.5mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

Date 30/9 | Medicine (print generic name) SPIRINOLACTONE | Tick if slow release

Route PO | Dose 50mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

Date 30/9 | Medicine (print generic name) FUROSEMIDE | Tick if slow release

Route PO | Dose 20mg | Frequency and NOW enter times MANE → 0800

Indication | Pharmacy

Prescriber signature [signature] | Print your name M COLLINS | Contact

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Pharmaceutical review:

Continue on discharge? Yes / No | Dispense? Yes / No | Duration: ..... days Qty: ..... | Date: | Pharmacist: | Print your name: | Prescriber's signature:

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 [signature] Print M COLLINS Date 30/9

Affix patient identification label here and overleaf

URN: N0XXXX

Family name: FITZPATRICK

Given names: HENRY

Address:

Date of birth: 14/09/38 Sex: M☒ F☐

First prescriber to print patient name and check label correct: HENRY FITZPATRICK

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

Regular medicines

Year 20 ..... Date and month →

Variable dose medicine

Date | Medicine (print generic name) | Drug level | Time level taken

Route | Frequency | Dose

Prescriber to enter dose times and individual dose

Indication | Pharmacy | Prescriber

Prescriber signature | Print your name | Contact | Time to be given: .....

Time given

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

Date: Pharmacist:

VTE risk assessed: Yes ☐ **Prophylaxis not required** ☒ **Contraindicated** ☐ Sig [signature] 30/9

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: .....

Date: Print your name:

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's signature:

PRESCRIBER MUST ENTER administration times

Date 30/9 | Medicine (print generic name) LANTUS | Tick if slow release

Route SubCut | Dose 10 UNITS | Frequency and NOW enter times NOCTE | 20.00

Indication | Pharmacy

Prescriber signature [signature] | Print your name MCOLLINS | Contact

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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

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Patient educated by: .....

Sign: .....

Date: .....

Given warfarin book: .....

Sign: .....

Date: .....

Reason for not administering

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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) | 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: .....

Date: Pharmacist:

Date: Print your name:

Date: Prescriber's signature:

Pharmaceutical review: