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. H. COLLINS Date. 29/10

FAMILY NAME GREEN	MRN No x x x x x x
GIVEN NAME MARK	☒ MALE ☐ FEMALE
D.O.B. 05 / 10 / 57	M.O.
ADDRESS	
LOCATION SURGICAL WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

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

REGULAR MEDICATIONS

YEAR 2018 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:.....

Date: Pharmacist Date:

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☒ Signature H. COLLINS Date 29/10

Date | Medication (Print Generic Name)

Route | Dose | Frequency & NOW Enter Times →

Indication: *VTE Prophylaxis* | Pharmacy

Prescriber Signature | Print Your Name | Contact

Mechanical Prophylaxis

Prescriber/NI Signature | Print Your Name | Contact

AM

PM

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

Prescriber

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
29/10	ATENALOL		PO	50mg	MANE	AF		H. COLLINS		

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

Date: Pharmacist Date:

Pharmaceutical Review:

Check if patient has another Medication Chart

2

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

Prescriber's Signature: Print Name: Contact:

REGULAR MEDICATIONS

YEAR 2018 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:.....

Date: Pharmacist Date:

Pharmaceutical Review:

Prescriber's Signature: Print Name: Contact:

Check if patient has another Medication Chart

3

WPIS_SI_CMII_MEDS.

NSW GOVERNMENT Health

Facility/Service: _____

Ward/Unit: .....

MEDICATION Chart No. ..... of .....

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

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 2018

FAMILY NAME GREEN	MRN NOXXXVV
GIVEN NAME MARK	☒ MALE ☐ FEMALE
D.O.B. 05/10/57	M.O.
ADDRESS	
LOCATION SURGICAL WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Date	Medication (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	Pharmacist Date:
29/10	SALBUTAMOL 100 micrograms	inh	2-4 puffs	PRN	8 puffs	COPD			H. Collins										
				PRN															
				PRN															
				PRN															
				PRN															
				PRN															
				PRN															

Check if patient has another Medication Chart