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

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
PEANUTS		

Sign....H–A.... Print.... D. HUNT .... Date.... 4/6

FAMILY NAME HAMILTON	MRN 1704201
GIVEN NAME JACKSON	☒ MALE ☐ FEMALE
D.O.B. 20 / 01 / 1990	M.O. EMERGENCY DR.
ADDRESS	
LOCATION EMERGENCY DEPARTMENT.	

PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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 →

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

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)
		Nurse 2

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

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	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	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: ......

Pharmaceutical Review:

Date: 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.............. 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	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	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	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	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	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: ......

Pharmaceutical Review:

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

NOT VALID ORDER UNLESS LEGIBLE

Check if patient has another Medication Chart

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
4/6	MORPHINE	IV	5mg	STAT	[signature]	D. HUNT	DM / LG	0810	

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

WP08_S1_CM09_MEDS

NOT A VALID ORDER UNLESS LEGIBLE

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20______

FAMILY NAME	HAMILTON	MRN	1704201
GIVEN NAME	JACKSON	☒ MALE ☐ FEMALE	
D.O.B.	20 / 01 / 1990	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

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

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

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