

Attach ADR Sticker

FAMILY NAME	HAMILTON	MRN	1704201
GIVEN NAME	JACKSON	<input checked="" type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
D.O.B.	20/01/1990	M.O.	EMERGENCY DR.
ADDRESS	PRESCRIPTION UNLESS IDENTIFIERS PRESENT		
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):.....

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)		
<input type="checkbox"/> Nil known	<input type="checkbox"/> Unknown (tick appropriate box or complete details below)	
Drug (or other)	Reaction/Type/Date	Initials
PEANUTS		

Sign: Holt Print: D. HUNT Date: 4/16

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

REGULAR MEDICATIONS		DATE & MONTH								
VARIABLE DOSE MEDICATION										
Date	Medication (Print Generic Name)	Drug level	Time level taken		Dose		Prescriber		Continue on discharge? Yes/No	
Route	Frequency	Dose		Prescriber		Time to be given:		Duration: days Qty		
Indication		Pharmacy		Time given & Sign		Prescriber Signature		Print Your Name		Contact
VTE risk assessed: Yes <input type="checkbox"/> Prophylaxis not required <input type="checkbox"/> Contraindicated <input type="checkbox"/> Signature: _____ Date: _____										
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Time to be given:		Duration: days Qty		Continue on discharge? Yes/No
Mechanical Prophylaxis										
Prescriber/NI Signature		Print Your Name		Contact		AM		PM		Continue on discharge? Yes/No
Date	WARFARIN (Marevan/Coumadin)	INR Result	Dose		mg		mg		mg	
Route	Prescriber to enter individual doses	Target INR Range	Dose		mg		mg		mg	
Indication		Pharmacy		Prescriber		1600 (Nurse 1)		Nurse 2		Continue on discharge? Yes/No
Prescriber Signature		Print Your Name		Contact		Duration: days Qty		Duration: days Qty		Continue on discharge? Yes/No
DOCTORS MUST ENTER administration times										
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
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: _____

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)

Pharmacist Signature: _____ Date: _____
 Pharmacist: _____ Date: _____
 Print Name: _____
 Contact: _____

REGULAR MEDICATIONS		DATE & MONTH								
DOCTORS MUST ENTER administration times										
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Date	Medication (Print Generic Name)	Route		Dose		Frequency & NOW Enter Times		Indication		Pharmacy
Prescriber Signature		Print Your Name		Contact		Tick if Slow Release		Continue on discharge? Yes/No		Duration: days Qty
Pharmaceutical Review:										
Check if patient has another Medication Chart										

NOT A VALID ORDER UNLESS LEGIBLE

