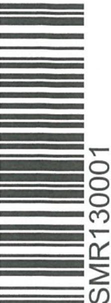
SMR130001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

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. [signature] Print. COLLINS Date. 28/09

FAMILY NAME HENDRICKS	MRN
GIVEN NAME GEOFF	☐ MALE ☐ FEMALE
D.O.B. 04 / 11 / 62	M.O.
ADDRESS	
LOCATION	

NOT A VALID 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........ DATE & MONTH →

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

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☒ Signature [signature] Date 25/09

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

DOCTORS MUST ENTER administration times

Date 25/09 (28/09)	Medication (Print Generic Name) Ramipril	Tick if Slow Release		27/09	26/09
Route PO	Dose 2.5mg / Frequency & NOW Enter Times mane		0800	RS	[initials]
Indication HT	Pharmacy				
Prescriber Signature [signature]	Print Your Name COLLINS / Contact				

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose / Frequency & NOW Enter Times	
Indication	Pharmacy	
Prescriber Signature	Print Your Name / Contact	

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: — Contact: — Print Name: — Prescriber's Signature:

Pharmaceutical Review:

Check if patient has another Medication Chart

NH606207 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended 2014

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	

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose / Frequency & NOW Enter Times	
Indication	Pharmacy	
Prescriber Signature	Print Your Name / Contact	

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose / Frequency & NOW Enter Times	
Indication	Pharmacy	
Prescriber Signature	Print Your Name / Contact	

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose / Frequency & NOW Enter Times	
Indication	Pharmacy	
Prescriber Signature	Print Your Name / Contact	

Date	Medication (Print Generic Name)	Tick if Slow Release
Route	Dose / Frequency & NOW Enter Times	
Indication	Pharmacy	
Prescriber Signature	Print Your Name / Contact	

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: — Contact: — Print Name: — Prescriber's Signature:

NOT A VALID ORDER UNLESS LEGIBLE

Pharmaceutical Review:

Check if patient has another Medication Chart