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: 25/09

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber **to Print Patient Name and Check Label Correct:** Weight(kg):............ Height(cm):............

SMR130001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REGULAR MEDICATIONS

YEAR 20........ **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:........

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 / PM

Prescriber/NI Signature | Print Your Name | Contact

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

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

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

DOCTORS MUST ENTER administration times

Field	Entry
Date	25/09
Medication (Print Generic Name)	Ramipril
Tick if Slow Release	
Route	PO
Dose	2.5mg
Frequency & NOW Enter Times	mane
Indication	HT
Pharmacy	
Prescriber Signature	[signature]
Print Your Name	Collins
Contact	

Time	25/09	26/09
0800	PS	[initials]

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:

Check if patient has another Medication Chart

WP20_S2_CM10_MEDS

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

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

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:

Check if patient has another Medication Chart

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

NOT A VALID ORDER UNLESS LEGIBLE

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
25/09	PANADOL	PO	1g	25/09/18 2000		B. COVENTRY		2000	
26/09	PANADOL	PO	1g	26/09/18		B. WALKER	SM	0600	

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**

NOT A VALID ORDER UNLESS LEGIBLE

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20_____

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Date	Medication (Print Generic Name)	Route	Dose & Hourly Frequency	Max PRN dose/24 hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
25/09	Salbutamol 200mcg	INH	4 puffs PRN						
			PRN						
			PRN						
			PRN						
			PRN						
			PRN						
			PRN						

Date | Time | Dose | Route | Sign

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

Date: .....

Pharmacist .....

Prescriber's Signature: .....

Print Name: .....

Contact: .....

Check if patient has another Medication Chart

Holes Punched as per AS2828.1:2012

BINDING MARGIN - NO WRITING

SMR130001