

Attach ADR Sticker

FAMILY NAME **HENDRICKS** MRN

GIVEN NAME **AEOFF** 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):

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 *Carlin* Date *25/09*

REGULAR MEDICATIONS

YEAR 20 DATE & MONTH →

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Drug level	Time level taken	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

VTE risk assessed: Yes Prophylaxis not required Contraindicated

Date	Medication (Print Generic Name)	Signature	Date

WARFARIN (Marevan/Coumadin)

Date	Route	Dose	Frequency & NOW Enter Times	Target INR Range	INR Result	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:
25/09	Ramipril	PO	2.5mg	once	MT	Carlin			

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

Pharmaceutical Review: Check if patient has another Medication Chart

WP20-S2-CM10-MEDS

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 hly	0600	1200	1800	2400	
Regular 8 hourly	8 hly	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

- 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)	Route	Dose	Frequency & NOW Enter Times	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

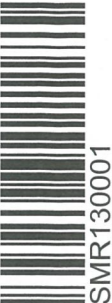
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Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW Enter Times	Pharmacy	Prescriber	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:

Pharmaceutical Review: Check if patient has another Medication Chart



Holes Punched as per AS2828.1: 2012 BINDING MARGIN - NO WRITING

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

NOT A VALID ORDER UNLESS LEGIBLE



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 Print Your Name	Given by	Time Given	Pharmacy
25/09	PARACET	PO	1g	25/09/18 2000	B. COVENTRY	S.	2000	
26/09	PARACET	PO	1g	26/09/18	R. WALKER	R. 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

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20 _____

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> 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:

NOT A VALID ORDER UNLESS LEGIBLE

MEDICATION CHART (MR71)

SMR130.001

Date	Medication (Print Generic Name)	Date		Continue on discharge? Yes / No Dispense? Yes / No Duration:days/Qty.....
25/09	SALBUTAMOL 200mcg			
Route	Dose & Hourly Frequency PRN Max PRN dose/24 hrs	Time		
INH	4 puffs			
Indication		Pharmacy	Dose	
Prescriber Signature Print Your Name		Contact	Route	
			Sign	

Check if patient has another Medication Chart

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BINDING MARGIN - NO WRITING

SMR130001

