SMR130010

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR) ☑ Nil known ☐ Unknown (tick appropriate box or complete details below)		
Drug (or other)	Reaction/Date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

Sign ..... Print ..... Date .....

FAMILY NAME	PEARSON	MRN	2276484
GIVEN NAME	OLIVER	☒ MALE	☐ FEMALE
D.O.B.	27 / 03 / 2009	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): 30 kg
Date weighed: 7/6/18

Height (cm): ..... B.S.A.(m²): .....
Gestational Age at Birth (wks).....

REGULAR MEDICATIONS

YEAR 20____ DATE & MONTH →

PRESCRIBER MUST ENTER administration times

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Name | Contact/Pager

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

Date .....

Pharmacist .....

Pharmacist Review:

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

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.

NOT A VALID ORDER UNLESS LEGIBLE

REASON FOR NOT ADMINISTERING
Codes MUST be circled

Absent	(A)
Fasting	(F)
Refused – Notify Prescriber	(R)
Vomiting	(V)
On Leave	(L)
Not available – obtain supply or contact Prescriber	(N)
Withheld – Enter reason in Clinical Record	(W)
Self Administration	(S)
Parent/Carer Administration	(P)

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

REGULAR MEDICATIONS

YEAR 20____ DATE & MONTH →

PRESCRIBER MUST ENTER administration times

Date | Medicine (Print Generic Name) | Tick if Slow Release

Route | **DOSE** | Frequency & NOW enter times →

Pharmacy/Additional Information

Indication | **DOSE** Calculation (eg. mg/kg per dose)

Prescriber Signature | Print Name | Contact/Pager

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

Date .....

Pharmacist .....

Pharmacist Review:

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

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NSW GOVERNMENT Health

Facility/Service:......................................

Ward/Unit: ....

PAEDIATRIC MEDICATION CHART ......1...... of ......1......

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ IV Heparin
☐ Inhalation ☐ Palliative Care ☐ Chemotherapy ☐ Other

ONCE ONLY MEDICINES

Date Prescribed	Medicine (Print Generic Name)	Route	DOSE	Date/Time to be given	Prescriber Signature	Prescriber Print Name	DOSE calc e.g. mg/kg per DOSE	Given by	Date/Time Given	Pharm
7/6	PARACETAMOL	PO	450mg	7/6/18 0950	[signature]	COOPER (RN)	15mg/kg	JC	7/6/18 0950	

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medicine (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 medicines brought in? ☐Y ☐N

Medicine & Formulation	Dose & Frequency	Duration	Medicine & Formulation	Dose & Frequency	Duration

NOT FOR ADMINISTRATION

Doctor/GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

WP10_S1_CM04_MEDS

PAEDIATRIC MEDICATION CHART PAEDIATRIC SMR130.010

NOT A VALID ORDER UNLESS LEGIBLE

FAMILY NAME	PEARSON	MRN	2276484
GIVEN NAME	OLIVER	☒ MALE	☐ FEMALE
D.O.B.	27 / 03 / 2009	M.O.	EMERGENCY DR.
ADDRESS			
LOCATION	EMERGENCY DEPARTMENT		

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:

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Weight (kg): ____________

Date weighed: ____________

Height (cm): .... B.S.A.(m²): ....

Gestational Age at Birth (wks).............................

Date	Medicine (Print Generic Name)		Date												Continue on discharge? Yes / No; Dispense? Yes / No; Duration? ......days / Qty?
Route	DOSE	Hourly Frequency PRN / Max PRN Dose/24 hrs	Time												
Pharmacy/Additional Information			Dose												
Indication	DOSE Calculation (eg. mg/kg per dose)		Route												
Prescriber Signature	Print Name	Contact/Pager	Sign												
Date	Medicine (Print Generic Name)		Date												Continue on discharge? Yes / No; Dispense? Yes / No; Duration? ......days / Qty?
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Route	DOSE	Hourly Frequency PRN / Max PRN Dose/24 hrs	Time												
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Route	DOSE	Hourly Frequency PRN / Max PRN Dose/24 hrs	Time												
Pharmacy/Additional Information			Dose												
Indication	DOSE Calculation (eg. mg/kg per dose)		Route												
Prescriber Signature	Print Name	Contact/Pager	Sign												

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

BINDING MARGIN - NO WRITING

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