

Attach ADR Sticker

FAMILY NAME PIERCE MRN 000 0000
 GIVEN NAME REBECCA MALE FEMALE
 D.O.B. 18 104 1977 M.O. DR CROZIER
 ADDRESS
 LOCATION SURGICAL WARD

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
 Nil known Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
 First Prescriber to Print Patient Name and Check Label Correct: Weight(kg):..... Height(cm):.....

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

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)

REGULAR MEDICATIONS		DATE & MONTH										
DOCTORS MUST ENTER administration times												
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Route	Dose		Frequency & NOW Enter Times		Prescriber Signature		Print Your Name		Contact		Duration: days Qty:	
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Route	Dose		Frequency & NOW Enter Times		Prescriber Signature		Print Your Name		Contact		Date:	
Indication		Pharmacy		Prescriber Signature		Print Your Name		Contact		Date:		
Pharmaceutical Review:												

Check if patient has another Medication Chart

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WPOI-SI-CMO9-DC

NOT A VALID ORDER UNLESS LEGIBLE

SMR130001
 Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING
 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended 2014