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 D. HUNT Date 21/5

FAMILY NAME WATSON	MRN 0407123
GIVEN NAME KAREN	☐ MALE ☒ FEMALE
D.O.B. 22 / 03 / 70	M.O. EMERGENCY DR.
ADDRESS	
LOCATION EMERGENCY	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

MEDICAL STUDENT USE ONLY NOT FOR ADMINISTRATION

SMR130001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

REGULAR MEDICATIONS

YEAR 20 18 DATE & MONTH →

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name) | Drug level | Time level taken

Route | Frequency | **Dose**

Prescriber to enter dose times and individual dose | Prescriber

Indication | Pharmacy | Time to be given:

Prescriber Signature | Print Your Name | Contact | 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

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 | 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:

(repeated for three medication boxes)

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 18 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:

(repeated for six medication boxes)

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

NOT A VALID ORDER UNLESS LEGIBLE

Pharmaceutical Review:

Check if patient has another Medication Chart

WP03_S1_CM12_MEDS

NSW GOVERNMENT | Health

Facility/Service: ______________________

Ward/Unit: ....

MEDICATION Chart No. 1 of 1

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
21/5	PARACETAMOL	PO	1g	STAT	[signature]	HUNT	MH	1000	
21/5	MORPHINE	IV	5mg	STAT	[signature]	HUNT	MH / JS	1000	

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

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1	Nurse Initials 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 18

FAMILY NAME WATSON	MRN 0407123
GIVEN NAME KAREN	☐ MALE ☒ FEMALE
D.O.B. 22 / 03 / 70	M.O. EMERGENCY DR.
ADDRESS	
LOCATION EMERGENCY	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
Prescriber Signature | Print Your Name | Contact | Sign
Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
Prescriber Signature | Print Your Name | Contact | Sign
Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
Prescriber Signature | Print Your Name | Contact | Sign
Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
Prescriber Signature | Print Your Name | Contact | Sign
Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
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Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

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

Date | Medication (Print Generic Name) | Date
Route | Dose & Hourly Frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose | Route
Prescriber Signature | Print Your Name | Contact | Sign
Continue on discharge? Yes / No Dispense? Yes / No Duration ....days/Qty ....

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

Check if patient has another Medication Chart

BINDING MARGIN - NO WRITING

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SMR130001