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. ..... Print. D. HUNT Date. 21/5

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

SMR130001

REGULAR MEDICATIONS

YEAR 20 18 DATE & MONTH → 21/5 | 22/5 | 23/5 | 24/5

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: 21/5 | Medication (Print Generic Name): CLEXANE

Route: S/C | Dose: 40mg | Frequency & NOW Enter Times: NOCTE

Indication: *VTE Prophylaxis* | Pharmacy

Prescriber Signature | Print Your Name: B. JOHNSTON | Contact

Mechanical Prophylaxis: TEDS.

Prescriber/NI Signature | Print Your Name: JOHNSTON | Contact

	21/5	22/5	23/5	24/5
2000	(W)	CF/MC	CF/MC	
AM	MH	MH	MH	MH
PM	GF	GF	GF	

Date: ..... Pharmacist: .....

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

Date: ..... Contact: .....

DOCTORS MUST ENTER administration times

Date: 21/5 | Medication (Print Generic Name): SERETIDE 250/50 MCG | Tick if Slow Release

Route: INH | Dose: 1 | Frequency & NOW Enter Times: BD.

Indication | Pharmacy

Prescriber Signature | Print Your Name: JOHNSTON | Contact

	21/5	22/5	23/5	24/5
0800	→	MH	MH	MH
2000	GF	GF	GF	

Date: 21/5 | Medication (Print Generic Name): SERTRALINE | Tick if Slow Release

Route: PO | Dose: 100mg | Frequency & NOW Enter Times: MANE

Indication | Pharmacy

Prescriber Signature | Print Your Name: JOHNSTON | Contact

	21/5	22/5	23/5	24/5
0800	→	MH	MH	MH

Date: 21/5 | Medication (Print Generic Name): PARACETAMOL. | Tick if Slow Release

Route: PO | Dose: 1g | Frequency & NOW Enter Times: QID.

Indication: PAIN | Pharmacy

Prescriber Signature | Print Your Name: JOHNSTON. | Contact

	21/5	22/5	23/5	24/5
0600	→	DC	DC	ES
1200	→	MH	MH	
1800		GF	GF	GF
2200		DC	DC	ES

Pharmaceutical Review:

Check if patient has another Medication Chart

2

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

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 → 21/5 | 22/5 | 23/5 | 24/5

DOCTORS MUST ENTER administration times

Date: 21/5 | Medication (Print Generic Name): TAZOCIN | Tick if Slow Release

Route: IV | Dose: 4.5g | Frequency & NOW Enter Times: TDS.

Indication | Pharmacy

Prescriber Signature | Print Your Name: JOHNSTON | Contact

	21/5	22/5	23/5	24/5
0600	→	DC/ES		
1400		MH/AS	MH/AS	
2200		DC/ES		CEASED.

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: ..... Pharmacist: .....

Contact: .....

Print Name: .....

Prescriber's Signature: .....

Check if patient has another Medication Chart

3

WP03_S2_CM24_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	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.	CROZIER
ADDRESS			
LOCATION	SURGICAL WARD.		

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	PRN Max PRN dose/24 hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
21/5	SALBUTAMOL 100 MCG.	INH	1 - 2 Q2H	12 PUFFS.	SOB.		[signature]	JOHNSTON	
21/5	ENDONE	PO	5-10mg Q4H	40mg	PAIN		[signature]	JOHNSTON	
21/5	ONDANSETRON	PO/IV	4-8mg Q4H	24mg	N + V		[signature]	JOHNSTON	

Administration record – ENDONE:

Date	21/5	21/5	22/5	22/5	22/5	23/5	24/5	24/5	24/5
Time	1300	1900	0100	0600	1700	0200	0030	0530	1000
Dose	10mg	10mg	10mg	10mg	5mg	5mg	5mg	10mg	10mg
Route	PO	PO	PO	PO	PO	PO	PO	PO	PO
Sign	MH/PS	GF/MC	DC/LS	DC/LS	GF/MC	DC/LS	ES/TH	ES/TH	MH/PS

Administration record – ONDANSETRON:

Date	21/5	22/5	22/5	24/5
Time	1600	0700	1600	0800
Dose	8mg	4mg	4mg	8mg
Route	IV	IV	IV	IV
Sign	GF/MC	MH/PS	GF/MC	MH/PS

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

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

Check if patient has another Medication Chart

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001