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: JOHNSTON Date: 27/5

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 → 27/5, 28/5

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: .....

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

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature Date

Date	Medication (Print Generic Name)	Tick if Slow Release	27/5	28/5
27/5	CLEXANE			
Route: SUBCUT	Dose: 40mg	Frequency & NOW Enter Times: NOCTE		
Indication: VTE Prophylaxis	Pharmacy			
Prescriber Signature: JOHNSTON	Print Your Name	Contact		
Mechanical Prophylaxis: TEDS.				
Prescriber/NI Signature	Print Your Name: JOHNSTON	Contact		
Date: WARFARIN (Marevan/Coumadin) select brand			INR Result	
Route	Prescriber to enter individual doses	Target INR Range	Dose	
Indication	Pharmacy		Prescriber	
Prescriber Signature	Print Your Name	Contact	1600 (Nurse 1)	
DOCTORS MUST ENTER administration times			Nurse 2	
27/5	SERETIDE 250/50		0800	JB JB
Route: INH	Dose: 1 puff	Frequency & NOW Enter Times: BD	2000	LM
Indication	Pharmacy			
Prescriber Signature: JOHNSTON	Print Your Name	Contact		
27/5	SERTRALINE		0800	JB
Route: PO	Dose: 100mg	Frequency & NOW Enter Times: MANE		
Indication	Pharmacy			
Prescriber Signature: JOHNSTON	Print Your Name	Contact		
27/5	PARACETAMOL		0600	TW TW
Route: PO	Dose: 1g	Frequency & NOW Enter Times: QID	1200	JB J
Indication	Pharmacy		1800	LM
Prescriber Signature: JOHNSTON	Print Your Name	Contact	2200	TW

Pharmaceutical Review:

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

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

Check if patient has another Medication Chart

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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

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

REGULAR MEDICATIONS

YEAR 20 18 — DATE & MONTH → 27/5, 28/5

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release	27/5	28/5
27/5	TARGIN 10/5 mg			
Route: PO	Dose: 1	Frequency & NOW Enter Times: BD	0800	JB/TS	JB/TS
Indication	Pharmacy		2000	LM/PS	
Prescriber Signature	Print Your Name: JOHNSTON	Contact			
27/5	AMPICILLIN		0600	TW/ED	TW/RO
Route: IV	Dose: 2g	Frequency & NOW Enter Times: Q6H	1200	JB/TS	
Indication	Pharmacy		1800	LM/PS	
Prescriber Signature	Print Your Name: JOHNSTON	Contact	2400	TW/RO	

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

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

Pharmaceutical Review:

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

Check if patient has another Medication Chart

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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

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:** ....

Order 1

Date: 27/5 — Medication (Print Generic Name): SALBUTAMOL. 100 MCG.
Route: INH — Dose & Hourly Frequency: i - ii Q2H — PRN — Max PRN dose/24 hrs: 12 PUFFS.
Indication: SOB — Pharmacy:
Prescriber Signature: [signature] — Print Your Name: JOHNSTON — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Order 2

Date: 27/5 — Medication (Print Generic Name): ENDONE
Route: PO — Dose & Hourly Frequency: 5-10mg Q4H — PRN — Max PRN dose/24 hrs: 40mg
Indication: PAIN — Pharmacy:
Prescriber Signature: [signature] — Print Your Name: JOHNSTON — Contact:

Date	27/5													
Time	1700													
Dose	5mg													
Route	PO													
Sign	LM/PS													

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

Order 3

Date: 27/5 — Medication (Print Generic Name): ONDANSETRON
Route: PO — Dose & Hourly Frequency: 4-8mg Q4H — PRN — Max PRN dose/24 hrs: 24mg
Indication: N + V — Pharmacy:
Prescriber Signature: [signature] — Print Your Name: JOHNSTON — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Order 4

Date: — Medication (Print Generic Name):
Route: — Dose & Hourly Frequency: — PRN — Max PRN dose/24 hrs:
Indication: — Pharmacy:
Prescriber Signature: — Print Your Name: — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Order 5

Date: — Medication (Print Generic Name):
Route: — Dose & Hourly Frequency: — PRN — Max PRN dose/24 hrs:
Indication: — Pharmacy:
Prescriber Signature: — Print Your Name: — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Order 6

Date: — Medication (Print Generic Name):
Route: — Dose & Hourly Frequency: — PRN — Max PRN dose/24 hrs:
Indication: — Pharmacy:
Prescriber Signature: — Print Your Name: — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Order 7

Date: — Medication (Print Generic Name):
Route: — Dose & Hourly Frequency: — PRN — Max PRN dose/24 hrs:
Indication: — Pharmacy:
Prescriber Signature: — Print Your Name: — Contact:

Date														
Time														
Dose														
Route														
Sign														

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

Pharmacist .... Date: ....

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

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001

Check if patient has another Medication Chart