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 H. COLLINS Date 10/8

FAMILY NAME WINTERS

MRN

GIVEN NAME FELIX

☒ MALE ☐ FEMALE

D.O.B. 09 / 08 / 31

M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

***First Prescriber* to Print Patient Name and Check Label Correct:** Weight(kg): 70 Height(cm): 181

REGULAR MEDICATIONS

YEAR 20 .... **DATE & MONTH** → 10/8 11/8 12/8 13/8

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 10/8

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

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

WARFARIN ~~(Marevan/~~Coumadin) select brand

Date 10/8		
Route PO	Prescriber to enter individual doses	Target INR Range 2-3
Indication PROSTHETIC VALVE		Pharmacy
Prescriber Signature	Print Your Name H. COLLINS	Contact

	10/8	11/8	12/8	13/8				
INR Result								
Dose	WH mg	WH mg	WH mg	WH mg	mg	mg	mg	mg
Prescriber								
1600 (Nurse 1)								
Nurse 2								

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

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose / Frequency & NOW Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Time	10/8	11/8	12/8	13/8
10/8	METOPROLOL	PO	146 MANE	CHF			H. COLLINS		0800				
10/8	RAMIPRIL	PO	5mg BD	HT			H. COLLINS		0800 2000				
10/8	ATORVOSTATIN	PO	10mg MANE	HYPERLIPIDAEMIA			H. COLLINS		0800				

Tick if Slow Release

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

Pharmaceutical Review:

Check if patient has another Medication Chart

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

WP22_S1_CM11_MEDS

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	Ⓐ
Fasting	Ⓕ
Refused – notify Dr	Ⓡ
Vomiting	Ⓥ
On leave	Ⓛ
Not available – obtain supply or contact Dr	Ⓝ
Withheld – enter reason in clinical record	Ⓦ
Self Administered	Ⓢ

REGULAR MEDICATIONS

YEAR 20 18 **DATE & MONTH** → 10/8 11/8 12/8 13/8

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose / Frequency & NOW Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Time	10/8	11/8	12/8	13/8
10/8	FUROSEMIDE	PO	40mg MANE	CHF			H. COLLINS		0800				
10/8	CEPHALEXIN	PO	500mg BD	PROPHYLAXIS			H. COLLINS		0800 2000				

Tick if Slow Release

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

Pharmaceutical Review:

Check if patient has another Medication Chart

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

NOT VALID UNLESS LEGIBLE

NSW GOVERNMENT | Health

Facility/Service: ARRH

Ward/Unit: SURGICAL

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
10/8	PROTHROMBINEX	IV	1750IU	10/8	[signature]	H. COLLINS	MK/TC	1400	
10/8	VITAMIN K	IV	10mg	10/8	[signature]	H. COLLINS	MK/TC	1400	

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

Date Time	Medication (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 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____

FAMILY NAME	WINTERS	MRN	
GIVEN NAME	FELIX	☒ MALE	☐ FEMALE
D.O.B.	09 / 08 / 31	M.O.	
ADDRESS			
LOCATION			

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
10/8	24RTEC	NASAL	1 SPRAY		HAYFEVER		[signature]	H. COLLINS	
10/8	PARACETAMOL	PO	1g QID	4g	PAIN		[signature]	H. COLLINS	

Administration record rows: Date / Time / Dose / Route / Sign

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

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR130001