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
PENICILLIN		

Sign..... Print BALAGAMA Date 15/05

FAMILY NAME CUNNIGHAM	MRN 000 0000
GIVEN NAME FREDRICK	☐ MALE ☐ FEMALE
D.O.B. 10/04/42	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..... DATE & MONTH → 15/5

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)
Route | Dose | Frequency & NOW Enter Times →
Indication | Pharmacy
VTE Prophylaxis
Prescriber Signature | Print Your Name | Contact

Mechanical Prophylaxis
Prescriber/NI Signature | Print Your Name | Contact

AM
PM

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

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release	
15/5	PERINDOPRIL		0800
Route PO	Dose 5mg	Frequency & NOW Enter Times MANE	
Indication HTN	Pharmacy		
Prescriber Signature	Print Your Name PALAGAMA	Contact	
15/5	ATORVASTATIN		2000
Route PO	Dose 40mg	Frequency & NOW Enter Times NOCTE	
Indication DYSLIPIDAEMIA	Pharmacy		
Prescriber Signature	Print Your Name PALAGAMA	Contact	
Date	Medication (Print Generic Name)	Tick if Slow Release	
Route	Dose	Frequency & NOW Enter Times →	
Indication	Pharmacy		
Prescriber Signature	Print Your Name	Contact	

Pharmaceutical Review:

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

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..... 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:.....

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

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

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING
NH606207 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended 2014
WP02_S1_CMMB_MEDS