

Attach ADR Sticker

FAMILY NAME	CUNNINGHAM	MRN	000 0000
GIVEN NAME	FREDRICK	<input checked="" type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
D.O.B.	10/04/42	M.O.	CROZIER
ADDRESS	PRESCRIPTION UNLESS IDENTIFY PRESENT		
LOCATION	SURGICAL WARD		

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
 Nil known Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials
PENICILLIN		

Sign: *JHE* Print: HAMPTON Date: 21/5

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
 First Prescriber to Print Patient Name and Check Label Correct: Weight(kg): Height(cm):

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

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Drug level	Time level taken	Dose	Prescriber	Indication	Pharmacy	Time to be given:	Continue on discharge? Yes/No	Dispense? Yes/No	Duration: days Qty:
21/5	CLETHANE			40mg NOCTE	JHE HAMPTON	VTE Prophylaxis	TEDS				
21/5	WARFARIN (Marevan/Coumadin)			1600 (Nurse 1)	JHE HAMPTON						
21/5	PERINDOPRIL			5mg MAE	JHE HAMPTON	HTN					
21/5	ATORVASTATIN			40mg MAE NOCTE	JHE HAMPTON	DISLIPIDAEMIA					
21/5	FERROUS FUMARATE			200mg MAE	JHE HAMPTON	ANAEMIA					

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	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:
21/5	PARACETAMOL	PO	1g	QID	PAIN		JHE HAMPTON					
21/5	TARGIN	PO	10/5mg	BD	PAIN		JHE HAMPTON					

WARFARIN EDUCATION RECORD
 Patient Educated by: Sign: Date: Given Warfarin Book: Sign: Date:

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)

Pharmacist: Print Name: Contact: Date: Duration: days Qty:

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

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	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:
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Pharmacist: Print Name: Contact: Date: Duration: days Qty:

SMR130001
 Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING
 NH606207 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended 2014

NOT A VALID ORDER UNLESS LEGIBLE



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	

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? <input type="checkbox"/> Y <input type="checkbox"/> 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

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20 18

FAMILY NAME	CUNNINGHAM	MRN	000 0000
GIVEN NAME	FREDRICK	<input type="checkbox"/> MALE	<input type="checkbox"/> 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: _____

Date	Medication (Print Generic Name)	Date	21/5	21/5	22/5	23/5	23/5	24/5	Continue on discharge? Yes/No		
21/5	ENDONE								Yes/No		
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time	10 00	18 00	16 00	10 00	20 00	09 00	Duration
Indication	Pharmacy	Dose	Route	Sign							days/Qty
Prescriber Signature	Print Your Name	Contact	Sign								
[Repeat structure for multiple rows with handwritten data for ENDONE]											

Check if patient has another Medication Chart

NOT A VALID ORDER UNLESS LEGIBLE

MEDICATION CHART (MR71)

SMR130.001

Holes Punched as per AS2828.1:2012
BINDING MARGIN - NO WRITING



SMR130001