TRAINING ONLY

(Affix identification label here)

URN: 45678

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

First Prescriber to Print Patient Name and Check Label Correct: M. Linnane

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

YEAR: 20xx

Date	Medication (Print Generic Name)				
xx/xx/xx	Oxycodone hydrochloride				
Route	Dose	Hourly Frequency	PRN	Max PRN dose/24hrs	
PO			PRN	50-60mg	
Indication			Pharmacy		
Pain			CQU Sim. Pharm.		
Prescriber Signature	Print Your Name			Contact	
MLee	Monica Linnane			9141	

Date	Medication (Print Generic Name)				
xx/xx/xx	Tramadol hydrochloride				
Route	Dose	Hourly Frequency	PRN	Max PRN dose/24hrs	
PO			PRN	400mg	
Indication			Pharmacy		
Pain			CQU Sim. Pharm		
Prescriber Signature	Print Your Name			Contact	
MLee	Monica Linnane			9141	

Date	Medication (Print Generic Name)				
xx/xx/xx	Ondansetron				
Route	Dose	Hourly Frequency	PRN	Max PRN dose/24hrs	
PO			PRN	24mg	
Indication			Pharmacy		
Nausea			CQU Sim. Pharm.		
Prescriber Signature	Print Your Name			Contact	
MLee	Monica Linnane			9141	

Date	Medication (Print Generic Name)				
xx/xx/xx	Metoclopramide				
Route	Dose	Hourly Frequency	PRN	Max PRN dose/24hrs	
PO			PRN	30mg	
Indication			Pharmacy		
Nausea			CQU Sim. Pharm.		
Prescriber Signature	Print Your Name			Contact	
MLee	Monica Linnane			9141	

Date	Medication (Print Generic Name)				
xx/xx/xx	Paracetamol				
Route	Dose	Hourly Frequency	PRN	Max PRN dose/24hrs	
PO			PRN	4g	
Indication			Pharmacy		
Pain			CQU Sim. Pharm.		
Prescriber Signature	Print Your Name			Contact	
MLee	Monica Linnane			9141	

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

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

Administration record (each entry): Date / Time / Dose / Route / Sign

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

(repeated for each of the seven entries)

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

Prescriber's Signature: .... Name (Print): .... Date: ....

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

v12.00 - 06/2013

Mat. No.: 10180243

SW001

Queensland Government

Facility / Service: CQUni Hospital

Year: 20xx Ward / Unit: Surgical

MEDICATION CHART 1 of 1

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL / Insulin ☐ Acute Pain ☐ Clozapine
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin ☐ Other

ONCE ONLY, PRE-MEDICATION, TELEPHONE ORDERS AND NURSE INITIATED MEDICINES
(Telephone orders MUST be signed within 24 hours of order)

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

Medicines Prior to Presentation to Hospital
(Prescribed, over the counter, complementary) Own medications brought in? ☐ Y ☐ N Administration Aid (specify): ....

Medication	Dose and frequency	Duration	Medication	Dose and frequency	Duration

NOT FOR ADMINISTRATION

GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

MEDICATION CHART

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TRAINING ONLY

REGULAR MEDICATIONS

YEAR 20xx DATE and MONTH →

VARIABLE DOSE MEDICATION

Drug level
When level taken
Dose
Prescriber
Time to be given:
Time given

Date | Medication (Print Generic Name)
Route | Frequency
Prescriber to enter dose times and individual doses
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

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

Date: .....

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

Date | Medication (Print Generic Name) | Within 12hrs of invasive procedure (pre/post): ☐ Give ☐ Withhold ☐ N/A
Route | Dose | Frequency and Enter Times →
Indication | Prescriber Signature | Print Your Name | Contact

VTE Prophylaxis

Mechanical Prophylaxis | Pharmacy | AM
Prescriber/NI Signature | Print Your Name | Contact | PM

Date | **WARFARIN** (Marevan/Coumadin) select brand | INR Result
Route | Prescriber to enter individual doses | Target INR Range | **Dose** mg mg mg mg mg mg mg mg mg mg mg
Indication | Pharmacy | Prescriber
Prescriber Signature | Print Your Name | Contact | 1600 (Nurse 1)
DOCTORS MUST ENTER administration times | Nurse 2

Date: xx/xx/xx | Medication (Print Generic Name): Tarain 10|5 | Tick if Slow Release ✓
Route: PO | Dose | Frequency and Enter Times →
Indication: Pain | Pharmacy: CAN Sim. Pharm.
Prescriber Signature: Mlen | Print Your Name: Monica Linnane | Contact: 9141

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

Pharmaceutical Review:

Date: ..... Pharmacist: .....
Name (Print): .....
Prescriber's Signature: .....

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

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.

WARFARIN EDUCATION RECORD

Patient Educated by: .....
Sign: .....
Date: .....
Given Warfarin Book: .....
Sign: .....
Date: .....

REASON FOR NOT ADMINISTERING
Codes MUST be circled

Absent	A
Fasting	F
On leave	L
Not available - obtain supply and/or notify Dr, consider incident report	N
Refused - notify Dr	R
Self Administered - observed or claimed	S
Vomiting - notify Dr	V
Withheld - Enter reason in clinical record	W

Attach ADR Sticker

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

Drug (or other)	Reaction / Date	Initials

Sign: Mlen Print: M. Linnane Date: xx/xx/xx

(Affix identification label here and overleaf)

URN: 45678
Family name: Richards
Given name(s): Jo
Address:
Date of birth: 01 JAN 1970 Sex: ☐ M ☐ F ☐ I

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

First Prescriber to Print Patient Name and Check Label Correct: M. Linnane

Weight(kg): xx
Height(cm): xx

REGULAR MEDICATIONS

YEAR: ..... DATE and MONTH →

DOCTORS MUST ENTER administration times

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

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

Date: .....

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
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Route | Dose | Frequency and Enter Times →
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Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

Date | Medication (Print Generic Name) | Tick if Slow Release
Route | Dose | Frequency and Enter Times →
Indication | Pharmacy
Prescriber Signature | Print Your Name | Contact

Pharmaceutical Review:

Date: .....
Name (Print): .....
Prescriber's Signature: .....