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)	Route	Dose / Hourly Frequency	Max PRN dose/24hrs	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
xx/xx/xx	Oxycodone hydrochloride	PO	PRN	50 - 60 mg	Pain	CQU Sim. Pharm.	MLee	Monica Linnane	9141
xx/xx/xx	Tramadol hydrochloride	PO	PRN	400mg	Pain	CQU Sim. Pharm	MLee	Monica Linnane	9141
xx/xx/xx	Ondansetron	PO	PRN	24mg	Nausea	CQU Sim. Pharm.	MLee	Monica Linnane	9141
xx/xx/xx	Metoclopramide	PO	PRN	30mg	Nausea	CQU Sim. Pharm.	MLee	Monica Linnane	9141
xx/xx/xx	Paracetamol	PO	PRN	4g	Pain	CQU Sim. Pharm.	MLee	Monica Linnane	9141
			PRN						
			PRN						

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

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

(repeated for each of the 7 medication entries)

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

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

v12.00 - 06/2013
Mat. No.: 10180243
SW001

Queensland Government

MEDICATION CHART 1 of 1

Facility / Service: CQUni Hospital

Year: 20xx Ward / Unit: Surgical

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:

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MEDICATION CHART

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

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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

Pharmaceutical Review:

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