(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	COU Sim. Pharm.	MLee	Monica Linnane	9141
xx/xx/xx	Tramadol hydrochloride	PO	PRN	400mg	Pain	COU Sim. Pharm	MLee	Monica Linnane	9141
xx/xx/xx	Ondansetron	PO	PRN	24mg	Nausea	COU Sim. Pharm.	MLee	Monica Linnane	9141
xx/xx/xx	Metoclopramide	PO	PRN	30mg	Nausea	COU Sim. Pharm	MLee	Monica Linnane	9141
xx/xx/xx	Paracetamol	PO	PRN	4g	Pain	COU Sim. Pharm.	MLee	Monica Linnane	9141
			PRN						
			PRN						

Administration rows for each entry: Date / Time / Dose / Route / Sign

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

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	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

REGULAR MEDICATIONS

YEAR 20xx **DATE and MONTH** →

VARIABLE DOSE MEDICATION

Date

Medication (Print Generic Name)

Route

Frequency

Prescriber to enter dose times and individual doses

Indication

Pharmacy

Prescriber Signature

Print Your Name

Contact

Drug level

When level taken

Dose

Prescriber

Time to be given: ....

Time given

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ...... days Qty: ......

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

Prescriber/NI Signature

Print Your Name

Contact

AM

PM

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ...... days Qty: ......

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 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: xx/xx/xx

Medication (Print Generic Name): Targin 10/5

Tick if Slow Release ✓

Route: PO

Dose

Frequency and Enter Times

Indication: Pain

Pharmacy: CDU Sim. Pharm.

Prescriber Signature: Mlen

Print Your Name: Monica Linnane

Contact: 9141

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ...... days Qty: ......

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

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: ......

Pharmaceutical Review:

Date:

Pharmacist:

Date:

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

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

Medication (Print Generic Name)

Tick if Slow Release

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Dose

Frequency and Enter Times

Indication

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Dose

Frequency and Enter Times

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Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ...... days Qty: ......

Date

Medication (Print Generic Name)

Tick if Slow Release

Route

Dose

Frequency and Enter Times

Indication

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Prescriber Signature

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Continue on discharge? Yes / No

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Dose

Frequency and Enter Times

Indication

Pharmacy

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Contact

Continue on discharge? Yes / No

Dispense? Yes / No

Duration: ...... days Qty: ......

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: ......

Pharmaceutical Review:

Date:

Pharmacist:

Date:

Name (Print):

Prescriber's Signature: