(Affix identification label here)

URN: 246802

Family name:

Given name(s):

Address: 2A Unity Drive, Pleasantville

Date of birth: Sex: ☐ M ☐ F ☐ I

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: ....

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

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

For each medication: 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

Facility / Service: CQU Retirement Village

Year: 20xx Ward / Unit: ....

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

GP: **Community Pharmacy:**

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

MEDICATION CHART

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: .....
Pharmacist: .....

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

WARFARIN (Marevan/Coumadin) select brand

Date | 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

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
XX/XX/XX	Temazepam		PO			Insomnia	CDU Sim. Pharm	MLn	Monica Linnane	9141
XX/XX/XX	Benefibre		PO	2 teaspoons	Daily 0800	Constipation	CDU Sim. Pharm.	MLn	Monica Linnane	9141
XX/XX/XX	Aspirin		PO	100mg	Daily 0800	Hypertension	CDU Sim. Pharm.	MLn	Monica Linnane	9141

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

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 MLn Print M. Linnane Date XX/XX/XX

(Affix identification label here and overleaf)

URN: 246802
Family name: Thorne
Given name(s): Alex
Address: 2A Unity Drive, Pleasantville
Date of birth: 02 JAN 1924 Sex: ☒M ☐F ☐I

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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

Weight(kg): 46kg
Height(cm): 172cm

REGULAR MEDICATIONS

YEAR: 20XX 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
XX/XX	Citalopram		PO	20mg	Daily 0800	Depression	CDU Sim. Pharm	MLn	Monica Linnane	
XX/XX	Hydralazine hydrochloride		PO	50mg	BD 0800 2000	Hypertension	CDU Sim. Pharm.	MLn	Monica Linnane	
XX/XX	Rosuvastatin		PO	10mg	Daily 0800	Cholesterol	CDU Sim. Pharm.	MLn	Monica Linnane	
XX/XX	Valsartan		PO	80mg	Daily 0800	Hypertension	CDU Sim. Pharm.	MLn	Monica Linnane	

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

Pharmaceutical Review:

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