TRAINING ONLY

(Affix identification label here)

URN: 246802

Family name:

Given name(s):

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
xx/xx/xx	Paracetamol																	
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
PO	PRN	4g																
Indication	Pain	Pharmacy	CQV Sim. Pharm	Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														
M.L.	Monica Linnane	9141																

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
xx/xx/xx	Salbutamol																	
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
INH	PRN																	
Indication	COPD	Pharmacy	CQV Sim. Pharm.	Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														
M.L.	Monica Linnane	9141																

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
	PRN																	
Indication		Pharmacy		Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
	PRN																	
Indication		Pharmacy		Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
	PRN																	
Indication		Pharmacy		Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
	PRN																	
Indication		Pharmacy		Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														

Date	Medication (Print Generic Name)			Date														Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty: .....
Route	Dose Hourly Frequency	Max PRN dose/24hrs		Time														
	PRN																	
Indication		Pharmacy		Dose														
				Route														
Prescriber Signature	Print Your Name	Contact		Sign														

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

Name (Print): ..... Date: .....

Prescriber's Signature: .....

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

MEDICATION CHART 1 of 1

Facility / Service: CQV Retirement Village

Year: 20XX Ward / Unit: .....

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

MEDICATION CHART

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:

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

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TRAINING ONLY

REGULAR MEDICATIONS

YEAR 20xx DATE and MONTH → xx/xx

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Drug level	
		When level taken	
Route	Frequency	**Dose**	
	Prescriber to enter dose times and individual doses	Prescriber	
Indication	Pharmacy	Time to be given:	
Prescriber Signature	Print Your Name / Contact	Time given	

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

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

Pharmacist: ....

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	

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

Date: ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx/xx	Temazepam		
Route	Dose	Frequency and Enter Times →	
PO			
Indication	Pharmacy		
Insomnia	CQU Sim. Pharm		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane	9141	

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

Name (Print): ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx/xx	Benefibre		
Route	Dose	Frequency and Enter Times →	0800
PO	2 teaspoons	Daily	
Indication	Pharmacy		
Constipation	CQU Sim. Pharm.		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane	9141	

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

Prescriber's Signature: ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx/xx	Aspirin		
Route	Dose	Frequency and Enter Times →	0800
PO	100mg	Daily	
Indication	Pharmacy		
Hypertension	CQU Sim. Pharm.		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane	9141	

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

Pharmaceutical Review:

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 MLL 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: MLL M. Linnane
Weight(kg): 46kg
Height(cm): 172cm

REGULAR MEDICATIONS

YEAR: 20xx DATE and MONTH → xx/xx

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx	Citalopram		
Route	Dose	Frequency and Enter Times →	0800
PO	20mg	Daily	
Indication	Pharmacy		
Depression	CQU Sim. Pharm		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane		

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

Date: ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx	Hydralazine hydrochloride		
Route	Dose	Frequency and Enter Times →	0800
PO	50mg	BD	
Indication	Pharmacy		
Hypertension	CQU Sim. Pharm.		
Prescriber Signature	Print Your Name	Contact	2000
MLL	Monica Linnane		

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

Pharmacist: ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx	Rosuvastatin		
Route	Dose	Frequency and Enter Times →	0800
PO	10mg	Daily	
Indication	Pharmacy		
Cholesterol	CQU Sim. Pharm.		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane		

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

Date: ....

Date	Medication (Print Generic Name)	Tick if Slow Release	
xx/xx	Valsartan		
Route	Dose	Frequency and Enter Times →	0800
PO	80mg	Daily	
Indication	Pharmacy		
Hypertension	CQU Sim. Pharm.		
Prescriber Signature	Print Your Name	Contact	
MLL	Monica Linnane		

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

Name (Print): ....

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:....

Prescriber's Signature: ....

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: