TRAINING ONLY

(Affix identification label here)

URN:

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: ....

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	Ondansetron	PO		QID PRN	24mg	Nausea	CQU Sim. Pharm.	MLL	Monica Linnane	
xx/xx	Metoclopramide	PO		TDS PRN	30mg	Nausea	CQU Sim. Pharm.	MLL	Monica Linnane	
xx/xx	Paracetamol	PO		QID PRN	4g	Pain	CQU Sim. Pharm	MLL	Monica Linnane	
				PRN						
				PRN						
				PRN						
				PRN						

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

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: Medical

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:

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MEDICATION CHART

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 / Prescriber to enter dose times and individual doses	Dose / Prescriber
Indication	Pharmacy	Time to be given:
Prescriber Signature	Print Your Name / Contact	Time given

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		INR Result
Route	Prescriber to enter individual doses / Target INR Range	Dose (mg)
Indication	Pharmacy	Prescriber
Prescriber Signature / Print Your Name	Contact	1600 (Nurse 1) / Nurse 2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose / Frequency and Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
xx/xx	Salbutamol	NEB		Asthma	CQU Sim. Pharm.	[signature]	Monica Linnane	
xx/xx	Ipratropium bromide	NEB		Asthma	CQU Sim. Pharm.	[signature]	Monica Linnane	
xx/xx	Budesonide	NEB		Asthma	CQU Sim. Pharm.	[signature]	Monica Linnane	

Pharmaceutical Review:

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

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)

Reason	Code
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 [signature] Print M. Linnane Date xx/xx/xx

(Affix identification label here and overleaf)

URN: 13579
Family name: WEBB
Given name(s): Sam
Address: 200 Smiles St, Pleasantville
Date of birth: 01 JAN 1960 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 kg
Height(cm): xxx cm

REGULAR MEDICATIONS

YEAR: 20xx DATE and MONTH →

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose / Frequency and Enter Times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact
xx/xx	Flucloxacillin	IV		Infection	CQU Sim. Pharm.	[signature]	Monica Linnane	

Pharmaceutical Review:

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

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