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 entry): 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:

MEDICATION CHART

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TRAINING ONLY

REGULAR MEDICATIONS

YEAR 20xx **DATE and MONTH** → xx/xx

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: ......

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
Prescriber/NI Signature
Print Your Name
Contact
AM
PM

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

Pharmacist:

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: ......

Date:

DOCTORS MUST ENTER administration times

Date xx/xx
Medication (Print Generic Name) Salbutamol
Tick if Slow Release ☐
Route NEB
Dose
Frequency and Enter Times
Indication Asthma
Pharmacy CQU Sim. Pharm.
Prescriber Signature
Print Your Name Monica Linnane
Contact

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

Date xx/xx
Medication (Print Generic Name) Ipratropium bromide
Tick if Slow Release ☐
Route NEB
Dose
Frequency and Enter Times
Indication Asthma
Pharmacy CQU Sim. Pharm.
Prescriber Signature
Print Your Name Monica Linnane
Contact

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

Date xx/xx
Medication (Print Generic Name) Budesonide
Tick if Slow Release ☐
Route NEB
Dose
Frequency and Enter Times
Indication Asthma
Pharmacy CQU Sim. Pharm.
Prescriber Signature
Print Your Name Monica Linnane
Contact

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

Pharmaceutical Review:

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 Mlu 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 xx/xx
Medication (Print Generic Name) Flucloxacillin
Tick if Slow Release ☐
Route IV
Dose
Frequency and Enter Times
Indication Infection
Pharmacy CQU Sim. Pharm.
Prescriber Signature
Print Your Name Monica Linnane
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: ......

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: ......

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: