TRAINING ONLY

(Affix identification label here)

URN:

Family name:

Given name(s): Nasifah

Address: 34 Banksia Road, Pleasantville

Date of birth: 01 JAN 1950 Sex: ☐ M ☑ F ☐ I

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

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

**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 | PRN | 24mg | Nausea | CQU Sim. Pharm. | [signature] | Monica Linnane | |
| xx/xx | Metoclopramide | PO | PRN | 30mg | Nausea | CQU Sim. Pharm | [signature] | Monica Linnane | |
| xx/xx | Morphine hydrochloride trihydrate | PO | 2-4hr PRN | 24mg | Pain | CQU Sim. Pharm. | [signature] | Monica Linnane | |
| | | | PRN | | | | | | |
| | | | PRN | | | | | | |
| | | | PRN | | | | | | |
| | | | PRN | | | | | | |

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

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

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

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 Palliative Care

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 | 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:

NOT FOR ADMINISTRATION

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) | Drug level | When level taken | **Dose**
Route | Frequency | 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: ......

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

**VTE Prophylaxis**

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
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 | Tick if Slow Release |
|---|---|---|---|---|---|---|---|---|
| xx/xx | Movicol | PO | | Constipation | CQU Sim. Pharm. | MLL | Monica Linnane | |
| xx/xx | Paracetamol | PO | | Pain | CQU Sim. Pharm. | MLL | Monica Linnane | |
| xx/xx | Ibuprofen | PO | | Pain | CQU Sim. Pharm. | MLL | Monica Linnane | |

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

| 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 MLL Print M. Linnane Date xx/xx/xx

(Affix identification label here and overleaf)

URN:
Family name:
Given name(s): Nasifah
Address: 34 Banksia Road, Pleasantville
Date of birth: 01 JAN 1950 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 | Tick if Slow Release |
|---|---|---|---|---|---|---|---|---|---|
| xx/xx | Morphine Sulphate MR | PO | | Pain | CQU Sim. Pharm. | MLL | Monica Linnane | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

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

Pharmaceutical Review:

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