(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

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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: 20xx

Date	Medication (Print Generic Name)				Date													
xx/xx	Ondansetron				Time													
Route: PO	Dose: 4-8mg	Hourly Frequency: QID PRN	Max PRN dose/24hrs: 24mg		Dose													
Indication: Nausea		Pharmacy: CQU Sim. Pharm.			Route													
Prescriber Signature: MLL	Print Your Name: Monica Linnane		Contact:		Sign													

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

Date	Medication (Print Generic Name)				Date													
xx/xx	Metoclopramide				Time													
Route: PO	Dose: 10mg	Hourly Frequency: TDS PRN	Max PRN dose/24hrs: 30mg		Dose													
Indication: Nausea		Pharmacy: CQU Sim. Pharm.			Route													
Prescriber Signature: MLL	Print Your Name: Monica Linnane		Contact:		Sign													

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

Date	Medication (Print Generic Name)				Date													
xx/xx	Morphine hydrochloride trihydrate				Time													
Route: PO	Dose: 1-2mg	Hourly Frequency: 2-4hr PRN	Max PRN dose/24hrs: 24mg		Dose													
Indication: Pain		Pharmacy: CQU Sim. Pharm.			Route													
Prescriber Signature: MLL	Print Your Name: Monica Linnane		Contact:		Sign													

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

Date	Medication (Print Generic Name)				Date													
					Time													
Route	Dose	Hourly Frequency PRN	Max PRN dose/24hrs		Dose													
Indication		Pharmacy			Route													
Prescriber Signature	Print Your Name		Contact		Sign													

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

Date	Medication (Print Generic Name)				Date													
					Time													
Route	Dose	Hourly Frequency PRN	Max PRN dose/24hrs		Dose													
Indication		Pharmacy			Route													
Prescriber Signature	Print Your Name		Contact		Sign													

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

Date	Medication (Print Generic Name)				Date													
					Time													
Route	Dose	Hourly Frequency PRN	Max PRN dose/24hrs		Dose													
Indication		Pharmacy			Route													
Prescriber Signature	Print Your Name		Contact		Sign													

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

Date	Medication (Print Generic Name)				Date													
					Time													
Route	Dose	Hourly Frequency PRN	Max PRN dose/24hrs		Dose													
Indication		Pharmacy			Route													
Prescriber Signature	Print Your Name		Contact		Sign													

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

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

NOT FOR ADMINISTRATION

GP: **Community Pharmacy:**

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

MEDICATION CHART

REGULAR MEDICATIONS

YEAR 20xx DATE and MONTH → 4/1/x

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

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

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

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 | Prescriber | *1600* (Nurse 1) | Nurse 2

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

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

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	Movicol	PO		Constipation	CDW Sim. Pharm.		Monica Linnane		
xx/xx	Paracetamol	PO		Pain	CDW Sim. Pharm.		Monica Linnane		
xx/xx	Ibuprofen	PO		Pain	CDW Sim. Pharm.		Monica Linnane		

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

Prescriber's Signature: .....

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 Mlle 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	CDW Sim. Pharm.		Monica Linnane		

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

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

Prescriber's Signature: .....

Pharmaceutical Review: