Attach ADR Sticker

(Affix identification label here and overleaf)

ALLERGIES AND ADVERSE DRUG REACTIONS (ADR)
☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction / Date	Initials

Sign ..... Print ..... Date .....

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:

Weight(kg): .....

Queensland Government

MEDICATION CHART ☐ of ☐

Facility / Service: .....

Year: ..... 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

MEDICATION CHART

DO NOT WRITE IN THIS BINDING MARGIN

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

REGULAR MEDICATIONS

YEAR ..... DATE and MONTH →

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 | 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:.....

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:

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

SR = Sustained, modified or controlled release formulation.

Tick if Slow Release

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)

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(Affix identification label here and overleaf)

URN:

Family name:

Given name(s):

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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

Weight(kg): .....

Height(cm): .....

REGULAR MEDICATIONS

YEAR: ..... DATE and MONTH →

DOCTORS MUST ENTER administration times

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:

Pharmacist:

Name (Print):

Prescriber's Signature:

Pharmaceutical Review:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Sex: ☐ M ☐ F ☐ I

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

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See front page for details

AS REQUIRED "PRN" MEDICATIONS

YEAR: ....

Date	Medication (Print Generic Name)			Date
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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
Route	Dose Hourly Frequency PRN		Max PRN dose/24hrs	Time
Indication		Pharmacy		Dose / 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: ....

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