Cut off section

Attach ADR sticker

Allergies and adverse drug reactions (ADR)

☑ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign AS Print SINGH Date 3/9/18

URN: 219652

Family Name: Laurent

Given Names: Robert

Address: 55 Port Lane

Westbank, 3498

DOB: 12/05/1950 Sex: Male

First prescriber to print patient name and check label correct: MR ROBERT LAURENT

Weight (kg): 92 Height (cm): 182

Regular medicines

Year 20 18 Date and month → 3/9

Variable dose medicine

Date | Medicine (print generic name) | Drug level

Route | Frequency | Time level taken

Prescriber to enter dose times and individual dose | Dose

Indication | Pharmacy | Prescriber

Prescriber signature | Print your name | Contact | 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: AS Date: 3/9/18

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times →

Indication: VTE prophylaxis | Pharmacy

Prescriber signature | Print your name | Contact

Mechanical prophylaxis

Prescriber/NI signature | Print your name | Contact

AM check

PM check

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 Initial 1

Initial 2

PRESCRIBER MUST ENTER administration times

Date 3/9/18 | Medicine (print generic name): HYDROCORTISONE | Tick if slow release | 0200 ENTERED | 0800

Route IV | Dose: 100 mg | Frequency and NOW enter times: 6 HOURLY | 1400 | 2000

Indication: EXAC. ASTHMA | Pharmacy

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): CEFTRIAXONE | Tick if slow release | 0800

Route IV | Dose: 1 GRAM | Frequency and NOW enter times: DAILY

Indication: CHEST INFECTION | Pharmacy

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): ERYTHROMYCIN | Tick if slow release | 0200 ENTERED | 0800

Route IV | Dose: 1 GRAM , 6/24 | Frequency and NOW enter times | 1400 | 2000

Indication: CHEST INFECTION | Pharmacy

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Pharmaceutical review:

Pharmacist: Date:

Prescriber's signature: Print your name: Date:

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
Refused – notify prescriber	R
Vomiting	V
On leave	L
Not available – obtain supply or contact prescriber	N
Withheld – enter reason in clinical record	W
Self administered	S

Regular medicines

Year 20 18 Date and month → 3/9

PRESCRIBER MUST ENTER administration times →

Date 3/9/18 | Medicine (print generic name): PERINDOPRIL ARGININE | Tick if slow release | 0800

Route ORAL | Dose: 5mg | Frequency and NOW enter times: DAILY

Indication: HYPERTENSION | Pharmacy

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): PROPRANOLOL | Tick if slow release | 0800

Route ORAL | Dose: 160 mg | Frequency and NOW enter times: BD

Indication: HYPERTENSION | Pharmacy | 2000

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): ATORVASTATIN | Tick if slow release | 0800

Route ORAL | Dose: 40 mg | Frequency and NOW enter times: DAILY

Indication: HYPERCHOLESTEROLAEMIA | Pharmacy

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): METFORMIN | Tick if slow release | 0800

Route ORAL | Dose: 850 mg | Frequency and NOW enter times: TDS | 1400

Indication: TYPE 2 DIABETES | Pharmacy | 2000

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date 3/9/18 | Medicine (print generic name): GLARGINE INSULIN | Tick if slow release

Route S/C | Dose: 10 UNITS | Frequency and NOW enter times: PRIOR TO EVENING MEAL

Indication: TYPE 2 DIABETES | Pharmacy | 1730

Prescriber signature: AS | Print your name: SINGH | Contact: #456

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Pharmaceutical review:

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

Pharmacist: Date:

Prescriber's signature: Print your name: Date:

URN: 219652

Family Name: Laurent

Given Names: Robert

Address: 55 Port Lane

Westbank, 3498

DOB: 12/05/1950 Sex: Male

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20 18

First prescriber to print patient name and check label correct: MR ROBERT LAURENT

Date	Medicine (print generic name)				Date		
3/9/18	SALBUTAMOL MDI				Time		Continue on discharge? Yes / No
Route: INHALE	Dose Hourly frequency: 100-200 micrograms PRN		Max PRN dose/24 hrs: Up to 4 times DAILY		Dose		Dispense? Yes / No
Indication: ASTHMIA		Pharmacy			Route		Duration: ...... days Qty: ......
Prescriber signature: AS	Print your name: DR. A. SINGH		Contact: #456		Sign		Date:

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	Pharmacist:

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	Date:

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	Print your name:

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	

Date	Medicine (print generic name)			Date	
Route	Dose Hourly frequency PRN		Max PRN dose/24 hrs	Time	Continue on discharge? Yes / No
Indication		Pharmacy		Dose	Dispense? Yes / No
				Route	Duration: ...... days Qty: ......
Prescriber signature	Print your name		Contact	Sign	Prescriber's signature:

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Cut off section

Medication chart number 1 of 1

Facility/service: DEAKIN HOSPITAL

Ward/unit: 3 EAST

Additional charts
- [x] IV fluid
- [ ] Palliative care
- [ ] BGL/insulin
- [ ] Chemotherapy
- [ ] Acute pain
- [ ] IV heparin
- [ ] Other

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time of dose	Prescriber/Nurse Initiator (NI) Signature	Print your name	Given by	Time given	Pharmacy

Telephone orders (to be signed within 24 hours of order)

Date time	Medicine (print generic name)	Route	Dose	Frequency	Check initials N1	N2	Prescriber name	Pres. sign	Date	Record of administration Time / given by	Time / given by	Time / given by	Time / given by

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary) Own medicines brought in? Y [x] N [ ] Administration aid (specify) ...NIL...

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration
PERINDOPRIL ARGININE ō	5mg Daily				
PROPRANOLOL	160mg BD				
ATORVASTATIN	40 mg Daily				
METFORMIN	850mg TDS.				
GLARGINE (s/c)	10 Units at Night				

Not for administration

GP: DR ANASTER

Community pharmacy:

Sign: AS Print: A.SINGH Date: 3/9/18 Medicines usually administered by: PATIENT

NIMC (acute)