Facility/Service:.....

Route

(print generic name)

Dose

Date / time prescribed

T WRITE IN THIS BINDING MA	
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Affix patient identification label in this box
UR Number: Do not hand write these details, except when
Surname: adhesive barcode labels are unavailable
Given name:
Not a valid prescription unless identifiers present Second given name:
D.O.B.: Sex/Gender:
wat proposibles to print potiont name

See front page for details As required

	Not a vend given name:									me	PR dic	es							
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Check if patient has another Medication Chart

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Page 4 of 4

N1 N2 Signature Medicines taken prior to presentation to hospital (Prescribed, over the counter, complementary) Own medicines brought in? Y N Administration aid (specify) Dose and frequency Duration Dose and frequency Medicine

Medication chart number ____ of _

Print your name

Acute pain

☐ IV heparin

Given by

given

☐ BGL/insulin

Prescriber/Nurse Initiator (NI)

Chemotherapy

| IV fluid

Once only, pre-medication, telephone orders and nurse initiated medicines (Telephone orders MUST be signed within 24 hrs of order)

of dose Check initials

Telephone orders

Palliative care

Check if patient has another Medication Chart Page 1 of 4

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Community pharmacy:

Medicines usually administered by:

MR-NIMC-LS

NIMC

- LONG

STAY

	Affix patient identification label in this box
R Number:	Do not hand write these details, except when
	adhesive barcode labels are unavailable
econd given	Not a valid prescription unless identifiers present name:
.O.B.:	./Sex/Gender:

						D.O.B	.:	/	/	Sex	k/Gend	ler:																					
COMP	LETE ALER	T SHEET	IN MEDICA	AL RECOI		rst pres	criber	to print	patient																								
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Indication			Pharmacy		Prescriber																										charge		Provided Written informa
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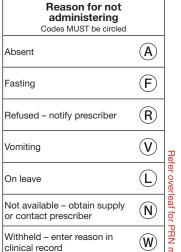
Anticoagulant education record Medicine Education Provided Declined Not appropriate Written Information Provided Declined Written information provided: CMI Other: Signature:Date: .. Designation:

Recommended administration times Guidelines only													
Morning		0800	Office										
Night	Nocte			1800 c	r 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								

or controlled release formulation.

If scored tablet, then half can be given. Dose must be swallowed without crushing.

SR = Sustained, modified



Check if patient has another Medication Chart

Medication
DO NOT WRITE IN THIS BINDING MARGIN

A VALID ORDER UNLESS LEGIBLE

Do Not v

NOT

Revised

August 2021

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