Black Dieline Pantone 485 Red

MR-NIMC-PAED

SAHMEDI000078

Medication

NOT A VALID ORDER UNLESS LEGIBLE

OFFICIAL: Sensitive//Medical in confidence

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: ....

First prescriber to print patient name and check label correct: ....

Attach ADR sticker

See front page for details

As required PRN medicines

Weight (kg): ....

Date weighed: ....

Ward/unit: ....

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

Prescriber's signature: .... Print your name: .... Pager: .... Date: .... Pharmacist: .... Date: ....

Check if patient has another Medication Chart OFFICIAL: Sensitive//Medical in confidence **Hospital Only Prescription**

DO NOT WRITE IN THIS BINDING MARGIN

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Government of South Australia

SA Health

Paediatric Medication chart number ...... of ......

Facility/service: ....

Ward/unit: ....

Additional charts

- ☐ IV fluid
- ☐ Inhalation
- ☐ BGL/insulin
- ☐ Palliative care
- ☐ Acute pain
- ☐ Chemotherapy
- ☐ IV heparin
- ☐ Other

Once only medicines

Date prescribed	Medicine (print generic name)	Route	**Dose**	Dose calc eg. mg/kg per dose	Date/time to be given	Prescriber Signature	Prescriber Print your name	Given by	Date/time given	Pharm

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

Date time	Medicine (print generic name)	Route	**Dose**	Dose calc eg. mg/kg per dose	Frequency	Check initials N1	Check initials N2	Prescriber name	Pres. sign	Date	Record of administration 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 ☐ N

Medicine and formulation	Dose and frequency	Duration	Medicine and formulation	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

SA Health

Revised August 2021

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NIMC - PAEDIATRIC

MR-NIMC-PAED

OFFICIAL: Sensitive//Medical in confidence

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

COMPLETE ALERT SHEET IN MEDICAL RECORD

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

Affix patient identification label in this box

UR Number: ....

Surname: ....

Given name: ....

Second given name: ....

D.O.B.: ..../ ..../.......... Sex/Gender: ....

Do not hand write these details, except when adhesive barcode labels are unavailable

Not a valid prescription unless identifiers present

First prescriber to print patient name and check label correct:

Weight (kg): ....

Date weighed: ....

Height (cm): .... BSA (m²): ....

Gestational age at birth (wks): ....

Regular medicines

Year 20.......... **Date and month** →

PRESCRIBER MUST ENTER administration times

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	**Frequency and NOW enter times**
Pharmacy/additional information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	**Frequency and NOW enter times**
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Date	Medicine (print generic name)	Tick if slow release
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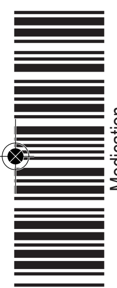
Pharmacy/additional information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Pharmaceutical review:

Date: .... Pharmacist: .... Date: .... Pager: .... Print your name: .... Prescriber's signature: ....



NOT A VALID ORDER UNLESS LEGIBLE

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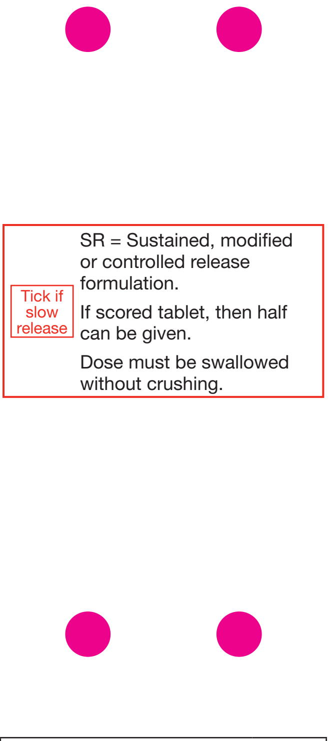
Recommended administration times

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	0800	1200	1700	2100



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.

Reason for not administering

Codes MUST be circled

Reason	Code
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
Parent/Carer administered	P

Regular medicines

Year 20 **Date and month** →

PRESCRIBER MUST ENTER administration times

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Pharmacy/additional information		
Indication	Dose calculation (eg. mg/kg per dose)	
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