Government of South Australia

Page .... of ....

MEDICATION AUTHORITY

Metropolitan referral unit phone: 1300 110 600 Fax: 1300 546 104

Allergies and Adverse Drug Reactions (ADR)

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

Medicine (or other)	Reaction / type / date	Initials

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

Affix patient identification label in this box

UR No: ....

Family Name: ....

Given Name: ....

Address: ....

....

Date of Birth: .... / .... / .... Sex: ....

Medicines required to be administered
(Prescriber must enter administration times)

Year 20...........

		Record of drug administration						
	Date / Admin Time							
Date | Medicine (print generic name) | Tick if Slow Release	*Last Dose Given Prior to Transfer (Date/Time):*							
Route | Dose | Frequency								
Indication								
Commence Date | Cease Date								
Prescriber Signature | Print your name | Contact								
Date | Medicine (print generic name) | Tick if Slow Release	*Last Dose Given Prior to Transfer (Date/Time):*							
Route | Dose | Frequency								
Indication								
Commence Date | Cease Date								
Prescriber Signature | Print your name | Contact								
Date | Medicine (print generic name) | Tick if Slow Release	*Last Dose Given Prior to Transfer (Date/Time):*							
Route | Dose | Frequency								
Indication								
Commence Date | Cease Date								
Prescriber Signature | Print your name | Contact								
Date | Medicine (print generic name) | Tick if Slow Release	*Last Dose Given Prior to Transfer (Date/Time):*							
Route | Dose | Frequency								
Indication								
Commence Date | Cease Date								
Prescriber Signature | Print your name | Contact								

Special instructions: ....

....

....

....

Doctors signature: .... Date: ....

Print Name: .... Contact/pager Number: ....