Government of South Australia
SA Health

Facility/Service:..................................

Ward/Unit:..

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

Additional charts

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

Once only, pre-medication, telephone orders and nurse initiated medicines

(Telephone orders MUST be signed within 24 hrs of order)

Date / time prescribed	Medicine (print generic name)	Route	**Dose**	Date/time of dose	Telephone orders Check initials N1	N2	Prescriber/Nurse Initiator (NI) Signature	Print your name	Given by	Time given	Pharmacy

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary) Own medicines brought in? Y ☐ N ☐ Administration aid (specify) ....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Check if patient has another Medication Chart **Hospital Only Prescription**

NIMC - LONG STAY

Affix patient identification label here and overleaf

URN:
Family name:
Given names:
Address:
Date of birth: **Sex:** **M** ☐ **F** ☐

Not a valid prescription unless identifiers present

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20..........

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

Date	Medicine (print generic name)			Date													
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time													
Indication		Pharmacy		Dose													
				Route													
Prescriber signature	Print your name		Contact	Sign													
Date	Medicine (print generic name)			Date													
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time													
Indication		Pharmacy		Dose													
				Route													
Prescriber signature	Print your name		Contact	Sign													
Date	Medicine (print generic name)			Date													
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time													
Indication		Pharmacy		Dose													
				Route													
Prescriber signature	Print your name		Contact	Sign													
Date	Medicine (print generic name)			Date													
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Indication		Pharmacy		Dose													
				Route													
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Date	Medicine (print generic name)			Date													
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				Route													
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Date	Medicine (print generic name)			Date													
Route	Dose Hourly frequency **PRN**		Max PRN dose/24 hrs	Time													
Indication		Pharmacy		Dose													
				Route													
Prescriber signature	Print your name		Contact	Sign													

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ....days Qty: ....
(repeated for each of the 7 orders)

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

Check if patient has another Medication Chart **Hospital Only Prescription**

NOT A VALID ORDER UNLESS LEGIBLE

DO NOT WRITE IN THIS BINDING MARGIN

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 here and overleaf

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: Sex: M ☐ F ☐

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

Weight (kg):.......... Height (cm): ....

Regular medicines

Year 20............. Date and month →

Date	**Warfarin**	Marevan / Coumadin select brand	INR Result
Route **oral**	Prescriber to enter individual doses	Target INR Range	**Dose** mg
Indication		Pharmacy	Prescriber
Prescriber signature	Print your name	Contact	**1600** Initial 1
			Initial 2

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

PRESCRIBER MUST ENTER administration times

Date	Medicine (print generic name)	Tick if slow release
Route	Dose	Frequency and NOW enter times →
Indication	Pharmacy	
Prescriber signature	Print your name	Contact

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 →
Indication	Pharmacy	
Prescriber signature	Print your name	Contact

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 →
Indication	Pharmacy	
Prescriber signature	Print your name	Contact

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 →
Indication	Pharmacy	
Prescriber signature	Print your name	Contact

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 →
Indication	Pharmacy	
Prescriber signature	Print your name	Contact

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

Pharmaceutical review:

Date: Pharmacist: Date: Contact: Print your name: Prescriber's signature:

Warfarin education record

Patient educated by: ....

Sign: ....

Date: ....

Given warfarin book: ....

Sign: ....

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

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

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

NOT A VALID ORDER UNLESS LEGIBLE

DO NOT WRITE IN THIS BINDING MARGIN

Medicine Chart - NIMC Long Stay: SA-1 – 01/2015 – 11507

Check if patient has another medication chart

'Hospital Only Prescription'

Refer overleaf for PRN medicines