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: .....

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20.....

NOT A VALID ORDER UNLESS LEGIBLE

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: .....

Date: ..... Pharmacist: .....

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: .....

Date: ..... Pharmacist: .....

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: .....

Date: ..... Contact: .....

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: .....

Prescriber's signature: ..... Print your name: .....

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: .....

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

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

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: .....

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

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Government of South Australia
SA Health

Facility/Service:.....

Ward/Unit:.....

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

Additional charts

☐ 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	Prescriber/Nurse Initiator (NI) 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	Check Initials 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 ☐ 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:

NIMC Acute Chart: SA-3 – 01/2015 – NIMC ACUTE 11959

NIMC - ACUTE (Version E)

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

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 →**

Variable dose medicine

Date | Medicine (print generic name) | Drug level | Time level taken

Route | Frequency — Prescriber to enter dose time and individual doses | **Dose** | Prescriber | Time to be given: ..... | Time given

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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

VTE risk assessed: Yes ☐ **Prophylaxis not required** ☐ **Contraindicated** ☐ Signature: Date:

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

VTE prophylaxis

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 **oral** | 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

Prescriber

1600 Initial 1

Initial 2

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

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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: .....

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

NOT A VALID ORDER UNLESS LEGIBLE

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

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.

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..... **Date and month →**

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

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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

Route | Dose | Frequency and NOW enter times →

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Prescriber signature | Print your name | Contact

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

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

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: .....

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

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

Refer overleaf for PRN medicines