Pantone 485 Red Black Dieline

MR-NIMC-LS NIMC - LONG STAY

SAHMEDI00079

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:..........................

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

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

Check if patient has another Medication Chart OFFICIAL: Sensitive//Medical in confidence **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 ☐ BGL/insulin ☐ Acute pain ☐ Other
☐ Palliative care ☐ Chemotherapy ☐ IV heparin

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:

SA Health

Revised August 2021

NIMC - ACUTE REGIONAL

MR-NIMC-ACR

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

NOT A VALID ORDER UNLESS LEGIBLE

Medication

Regular medicines

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

Variable dose medicine

Date | Medicine (print generic name)

Route | Frequency

Prescriber to enter dose time and individual doses

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Drug level	
Time level taken	
Dose	
Prescriber	
Time to be given:	
Time given	

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

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

Mechanical prophylaxis | **AM** check

Prescriber/NI signature | Print your name | Contact | **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								

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: ....

Pharmaceutical review:

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

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.

Anticoagulant education record

Medicine:..

Education

Provided ☐ Declined ☐
Not appropriate ☐

Written Information

Provided ☐ Declined ☐

Written information provided:
CMI ☐ Other: ☐ ....
Signature: ....
Designation: ....Date: ....

Reason for not administering

Codes MUST be circled

Absent	Ⓐ
Fasting	Ⓕ
Refused – notify prescriber	Ⓡ
Vomiting	Ⓥ
On leave	Ⓛ
Not available – obtain supply or contact prescriber	Ⓝ
Withheld – enter reason in clinical record	Ⓦ
Self administered	Ⓢ

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: ....
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:
....

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

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

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Duration: .... days Qty: ....

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

Refer overleaf for PRN medicines