Pantone 485 Red Black Dieline

MR-NIMC-LS NIMC - LONG STAY

SAHMEDI000081

Medication

NOT A VALID ORDER UNLESS LEGIBLE

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

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

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																
Prescriber signature	Print your name	Contact	Sign																

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			Route																
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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:........................ 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

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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, 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

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

SA Health

Revised August 2021

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

NIMC - ACUTE METRO

MR-NIMC-ACM

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 →

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:.....

Date:.....

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

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

Pharmacist:.....

Date:.....

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:.....

Contact:.....

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:.....

Print your name:.....

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:.....

Prescriber's signature:.....

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:

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	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

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

Date:.....

Pharmacist:.....

Contact:.....

Print your name:.....

Prescriber's signature:.....

Refer overleaf for PRN medicines

NOT A VALID ORDER UNLESS LEGIBLE

Medication

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