Government of South Australia
SA Health

Metropolitan Referral Unit

Please complete form and fax to 1300 546 104 or phone 1300 110 600

Paediatric Medication Authority

page .... of ....

Allergies and adverse drug reactions (ADR)

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

Medicine (or other)	Reaction/type/date	Initials

Print ....

Sign .... Date ....

Affix patient identification label here

URN: ....

Family Name: ....

Given Name: ....

Address: ....

....

Date of Birth: ...... / ...... / ...... Sex: ☐ M ☐ F

Weight (kg): ....

Regular medicines

Year 20 ....

Date and month →

Time ↓

Date	Medicine (print generic name)		Tick if slow release ☐
Route	Dose	Frequency	
Indication		Dose mg/kg	
Commence Date		Cease Date	
Prescriber signature	Print your name		Contact No

Date	Medicine (print generic name)		Tick if slow release ☐
Route	Dose	Frequency	
Indication		Dose mg/kg	
Commence Date		Cease Date	
Prescriber signature	Print your name		Contact No

Date	Medicine (print generic name)		Tick if slow release ☐
Route	Dose	Frequency	
Indication		Dose mg/kg	
Commence Date		Cease Date	
Prescriber signature	Print your name		Contact No

Special instructions: ....

....

....

....

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

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