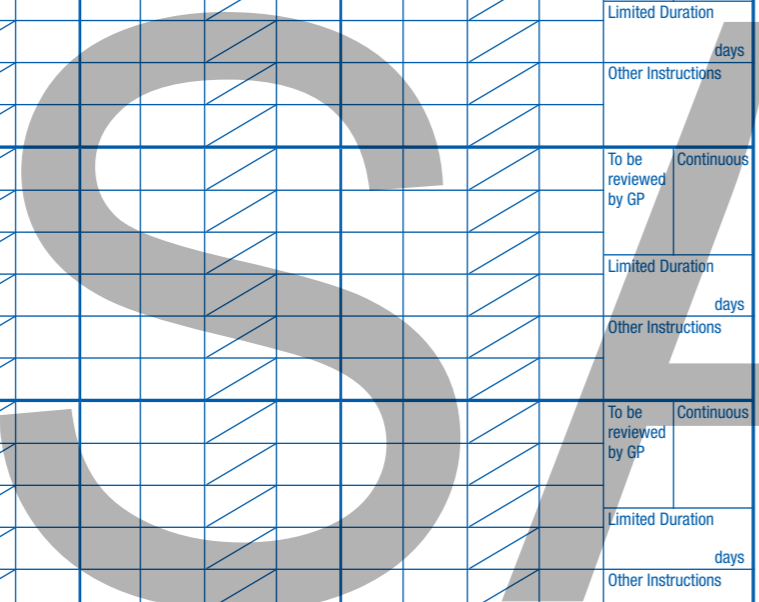


AS REQUIRED MEDICINES			DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DISCHARGE PRESCRIPTION	
DATE	MEDICINE(Approved Name)	PHARMACIST SUPPLY													To be reviewed by GP	Continuous
DOSE	ROUTE	FREQUENCY													Limited Duration	days
PRESCRIBER'S SIGNATURE		INDICATION													Other Instructions	
bleep No.																

NON-ADMINISTRATION OF MEDICINES
 When a patient does not receive a prescribed dose, the nurse should enter one of the code numbers given below in the administration box, to explain the reason for non-administration. Please attempt to obtain any unavailable medicines.

X. Prescriber's request
 2. Patient not on ward
 3. Patient unable to receive medicines/or no access
 4. Patient refused medicine
 5. Medicine unavailable
 6. See Notes

Prescriber's Signature authorising TTO _____ Bleep No. _____ Date _____ Pharmacy Date _____



DATE & START	INFUSION FLUID TYPE / STRENGTH	VOLUME	ROUTE	MEDICINE ADDED APPROVED NAME	DOSE	INFUSION RATE OR DURATION	PRESCRIBER'S SIGNATURE	PHARM	TIME START DATE	STOP DATE	VOL GIVEN	GIVEN BY
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.					

INTRAVENOUS AND SUBCUTANEOUS INFUSIONS
 INFUSIONS TO BE ADMINISTERED ONCE ONLY, UNLESS THE PRESCRIBER SPECIFIES THEY ARE TO BE CONTINUOUS*



IN-PATIENT MEDICATION ADMINISTRATION RECORD

DRUG ALLERGIES & SENSITIVITIES
 NONE KNOWN
 SIGNED DATE
 YES
 SIGNED DATE
 Drug / Allergen: _____ Description of Reaction: _____

THIS SECTION MUST BE COMPLETED

HOSPITAL No: _____
 SURNAME: _____
 FIRST NAME: _____
 ADDRESS: _____
 DATE OF BIRTH: _____
 Height (m) _____ Weight (kgs) _____ Surface Area (m²) _____ Age (if under 12) _____

ADDRESSOGRAPH

DATE OF ADMISSION _____ HOSPITAL _____ WARD _____ CONSULTANT _____

MULTIPLE MEDICATION CHARTS
 CHART OF

DETAILS OF SUPPLEMENTARY CHARTS
 TICK APPROPRIATE BOX
 ANTICOAGULANT OXYGEN
 SUPPLEMENTARY INFUSION CHART PATIENT CONTROLLED ANALGESIA/EPIDURAL
 INSULIN SYRINGE DRIVER
 OTHER (PLEASE SPECIFY) _____

MEDICATION ON SUPPLEMENTARY CHARTS SHOULD BE RECORDED ON THE DRUG CHART

PRESCRIPTION FOR ONCE-ONLY and PRE-ANAESTHETIC MEDICATION

DATE	MEDICINE (APPROVED NAME)	DOSE	ROUTE	TIME TO BE GIVEN	PRESCRIBER'S SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					
					bleep No.					

MEDICINES MANAGEMENT

MEDICATION HISTORY OBTAINED FROM:
 PATIENT GP NH/RH CARER
 PODS OTHER

COMPLIANCE ISSUES

INITIALS DATE

MEDICINES RECONCILED
 INITIALS DATE

GP DETAILS COMMUNITY PHARMACY DETAILS

COMMENTS / NOTES

DISCHARGE PRESCRIPTION WRITTEN
 INITIALS DATE

IN-PATIENT MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME HEALTH RECORD NUMBER
 MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800); BEDTIME (around 2200)

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY			REGULAR MEDICINES		MONTH		YEAR		DISCHARGE PRESCRIPTION	
DATE	ROUTE	SPECIFY TIME IF REQUIRED	DOSE	SIGN DOSE CHANGE	MEDICINE (Approved Name)	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE	PHARMACIST	To be reviewed by GP	Continuous
							bleep No.			
Morning										
Midday										
Evening										
Bedtime										

CHART MUST BE RE-WRITTEN BEFORE FURTHER DOSES ARE ADMINISTERED

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Prescriber's Signature authorising TTO Bleep No. Date Pharmacy Date

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DATE	ROUTE	SPECIFY TIME IF REQUIRED	DOSE	SIGN DOSE CHANGE	MEDICINE (Approved Name)	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE	PHARMACIST	To be reviewed by GP	Continuous
							bleep No.			
Morning										
Midday										
Evening										
Bedtime										

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DATE	ROUTE	SPECIFY TIME IF REQUIRED	DOSE	SIGN DOSE CHANGE	MEDICINE (Approved Name)	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE	PHARMACIST	To be reviewed by GP	Continuous
							bleep No.			
Morning										
Midday										
Evening										
Bedtime										

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