URN:
Family name:
Given names:
Address:

Not a valid prescription unless identifiers present

Date of birth: Sex: M ☐ F ☐
Medicare No: PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

First prescriber to print patient name and check label correct:

Approved pharmacy details: ....
Pharmacy approval no: ....

Attach ADR Sticker
See front page for details

Cut off section

EXAMPLE ONLY

As required PRN medicines

Brand substitution not permitted ☐ PBS/RPBS Year

Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
Start Date ...... /	Medicine (print generic name)/form	Date	Continue on discharge? Y / N
Route	Dose *and* hourly frequency PRN	Time	Dispense? Y / N
Indication	Max PRN dose/24hr	Dose	Duration: .... days Qty: ....
SAC/AAN	Pharmacy Imprest S8 S4R	Route	Prescriber's signature: ....
Prescriber signature	Print Name	Sign	Date: ....
	Pharmaceutical review:		

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Hospital name..
Hospital Provider number..
Ward.. Team..

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

Additional charts
☐ Variable dose ☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other ☐ Palliative care ☐ Chemotherapy ☐ Anticoagulation

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months
First prescriber to complete:
Initials:

Authority Prescription Number
XXXXXXXX

ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES

Date/Time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator Signature	Print your name	Given by	Date/Time Given	Pharmacy

TELEPHONE ORDER (to be signed within 24 hours of order)

Date/ Time	Medicine (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr 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)

☐ See WA MMP **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: ....

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

HCCXXX

XXXX
08/22

Check if patient has another medication chart

WA Hospital Medication Chart – Short Stay

MR XXX

Cut off section

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

Sign ..... Print ..... Date .....

Affix patient identification label here and overleaf

URN:
Family name:
Given names:
Address:
Date of birth: Sex: M ☐ F ☐
Medicare No: PBS/RPBS Entitlement No.
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

Not a valid prescription unless identifiers present

First prescriber to print patient name and check label correct:

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

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year _____

Variable dose medicine — Date and month →

Start Date ...../...../ | Medicine (print generic name)/form | Drug level
Route | Frequency — Prescriber to enter dose times and individual dose | Time level taken
Dose
Indication | Pharmacy | Imprest | Prescriber
Prescriber signature | Print name | SAC/AAN | Time to be given
Nurse initial

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:
Prescriber's signature:
Date:

Venous Thromboembolism (VTE) risk assessment / Anticoagulation

☐ **VTE risk considered** (refer guidelines) ☐ **Bleeding risk considered**

Pharmacological Prophylaxis: ☐ Indicated* ☐ Not Indicated ☐ Contraindicated
*Consider surgical and anaesthetic implications prior to prescribing

Mechanical Prophylaxis: ☐ GCS ☐ IPC ☐ VFP ☐ Not Indicated ☐ Contraindicated

Key: GCS – Graduated Compression Stockings; IPC – Intermittent Pneumatic Compression; VFP – Venous Foot Pumps

Risk Assessment completed by: (name)	Date/Time	Continue Y / N

If risk changes document VTE prophylaxis requirements on new chart

☐ **Warfarin / Anticoagulant in use**
Refer to Anticoagulation Chart for administration details

Additional Charts – Tick if in use

☐ Blood Glucose Level (BGL) monitoring (☐ Subcutaneous Insulin or ☐ Intravenous Insulin Infusion)
☐ Clozapine ☐ Intravenous (IV) Fluid ☐ Chemotherapy
☐ Agitation & arousal ☐ Palliative care ☐ Acute Pain
☐ Long acting injection ☐ Variable dose ☐ Other .....

Year 20..... **DATE AND MONTH** →
Prescriber MUST ENTER administration times ↓

Start Date ...../...../ | Medicine (print generic name)/form — Tick if slow release
Route | Dose *and* Frequency — and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:
Prescriber's signature:
Date:

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.

Reason for not administering
Codes MUST be circled

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

SAC: Streamline Authority Code
AAN: Authority Approval Number

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year _____

Date and month →
Prescriber MUST ENTER administration times →

Start Date ...../...../ | Medicine (print generic name)/form — Tick if slow release
Route | Dose *and* Frequency — and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN

Continue on discharge? Y / N
Dispense? Y / N
Duration: .....days Qty:
Prescriber's signature:
Date:

Pharmaceutical review:

Check if patient has another medication chart

Check if patient has another medication chart