URN:	Not a valid prescription unless identifiers present
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

First prescriber to print patient name and check label correct:

....

Approved pharmacy details:

....

Pharmacy approval no:

....

Attach ADR Sticker

See front page for details

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

Cut off section

PBS Hospital Medication Chart A (Acute) – 1 July 2016 – © Commonwealth of Australia 2016 – WA Version 1

Hospital name...

Hospital Provider number...

Ward.......................................Team...

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

Additional charts

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

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	Prescriber/Nurse/Midwife Initiator: Print your name	Given by	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

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 08/17

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.

Not a valid prescription unless identifiers present

☐ 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:

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

☐ Insulin (☐ Subcutaneous or ☐ Intravenous Infusion)
☐ Intravenous (IV) Fluid ☐ Chemotherapy
☐ Acute Pain ☐ Palliative Care
☐ Clozapine ☐ Other .....

Year 20..... **DATE AND MONTH** →
Doctors 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

Check if patient has another medication chart

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year _____

Date and month →
Prescriber to 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:

Check if patient has another medication chart