WA LONG STAY MEDICATION CHART

Cut Off Section

Health Service Logo

Facility/Service: ....

Ward/Unit: ....

Consultant: ....

MEDICATION Chart No. .... of ....

ADDITIONAL CHARTS

☐ IV Fluids ☐ BGL/Insulin ☐ Acute Pain ☐ Variable Dose

☐ Palliative Care ☐ Chemotherapy ☐ Anticoagulation ☐ Other

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

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of Dose	Prescriber or Nurse/Midwife Initiator Signature	Prescriber or Nurse/Midwife Initiator Print Your Name	Given By	Time Given	Pharmacy

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date Time	Medication (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) Own medications brought in? ☐ Y ☐ N Administration Aid (specify) ....

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

NOT FOR ADMINISTRATION

GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

WA LONG STAY MEDICATION CHART

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

URN:

Family name:

Given names:

Address:

Date of birth: Sex: ☐ M ☐ F

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

1st Prescriber to Print Patient Name and Check Label Correct: ....

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

YEAR 20.........

Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		
Date	Medication (Print Generic Name)				Date		Continue on discharge? Yes / No; Dispense? Yes / No; Duration: ...... days Qty: ......
Route	Dose	Hourly Frequency	PRN	Max Dose/24 hrs	Time		
Indication		Pharmacy			Dose / Route		
Prescriber Signature	Print Your Name		Contact		Sign		

Prescriber's Signature: .... Print your name: .... Contact No: .... Date: .... Pharmacist: .... Date: ....

DO NOT WRITE IN THIS BINDING MARGIN

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

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

Drug (or other)	Reaction/Type/Date	Initials

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

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

URN:

Family name:

Given names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Date of birth: Sex: ☐ M ☐ F

1st Prescriber to Print Patient Name and Check Label Correct:

.....

Weight (kg):.....

Height (cm):.....

Cut Off Section

Warfarin / Anticoagulant in use
(circle as appropriate)

REFER TO ANTICOAGULATION CHART FOR ADMINISTRATION DETAILS

REGULAR MEDICATIONS

YEAR 20..... **DATE & MONTH →**

DOCTORS MUST ENTER administration times

Date | Medication (Print Generic Name) | Tick if Slow Release

Route | Dose | Frequency & NOW Enter Times →

Indication | Pharmacy

Prescriber Signature | Print Your Name | Contact

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

(This block repeated 6 times)

Clinical Pharmacist Review:

Date:.....
Pharmacist:.....
Print your name:.....
Contact No:.....
Prescriber's Signature:.....
Date:.....

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 NURSE/MIDWIFE NOT ADMINISTERING
Codes MUST be circled

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

DO NOT WRITE IN THIS BINDING MARGIN

The Department of Health WA acknowledges the significant contribution of the Queensland Health Medication Management Services.
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