WA LONG STAY MEDICATION CHART

CUT OFF SECTION

Hospital Name Here

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 / 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 MR XXX

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														
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Prescriber Signature		Print Your Name		Contact	Sign														
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Route	Dose	Hourly Frequency	**PRN**	Max Dose/24 hrs	Time														
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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: Pharmacist: Date: Contact No: Print your name: Prescriber's Signature:

DO NOT WRITE IN 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):.....

WA LONG STAY MEDICATION CHART

CUT OFF SECTION

Venous Thromboembolism (VTE) risk assessment

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

Pharmacological Prophylaxis: ☐ Indicated* ☐ Not Indicated ☐ Contraindicated

*Consider surgical and anaesthetic implications prior to prescribing on Anticoagulation Chart

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:

☐

Warfarin / Anticoagulant in use

Refer to Anticoagulation Chart for administration details

REGULAR MEDICATIONS

YEAR 20..... **DATE & MONTH →**

DOCTORS MUST ENTER administration times

Each medication block:

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:.....

Date: ..... Pharmacist: ..... Date: .....

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

Clinical Pharmacist 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 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 BINDING MARGIN

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

Version 3 Revised July 2015

HCHXXXXXXXX

XXxxx
07/15