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

As required PRN medicines

Brand substitution not permitted ☐ PBS/RPBS Year

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

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart A (Acute) © Commonwealth of Australia 2016 – As amended 2019 (Version 1.1)

Cut off section

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

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

Additional charts
☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other
☐ Palliative care ☐ Chemotherapy ☐ IV heparin

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months Initials:

Authority Prescription Number

Once only and nurse initiated medicines and pre-medications/Telephone orders

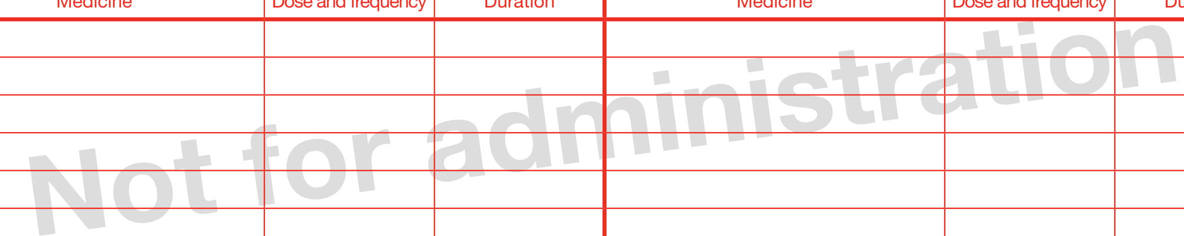
Date/time prescribed	Medicine (print generic name)/form	Route	**Dose**	Frequency	Check initials N1	Check initials N2	Prescriber/ nurse initiator name	Prescriber /nurse initiator sign	Date	Record of administration Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	Pharmacy

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary)

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

Check if patient has another medication chart

PBS Hospital Medication Chart A (Acute)

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:

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:

....

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

Regular Medicines

Brand substitution not permitted ☐ PBS/RPBS Year

Variable dose medicine Date and month →

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

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

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Start Date ...... /	Medicine (print generic name)/form	
Route	Dose *and* Frequency and now enter times →	
Indication **VTE prophylaxis**	Pharmacy	
Prescriber	SAC/AAN	
Mechanical prophylaxis		AM check
Signature / NI signature	Print name	PM check

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

Start Date ...... /	**Warfarin**	**Marevan / Coumadin** Circle brand	INR Result
Route	Prescriber to enter individual doses	Target INR Range	Dose (mg mg mg mg mg mg mg mg mg mg)
Indication	Pharmacy		Prescriber
Prescriber signature			Initial 1 18:00
			Initial 2

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

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	
Prescriber signature	SAC/AAN	

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

Start Date ...... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency and now enter times →	
Indication	Pharmacy	
Prescriber signature	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

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.

Anticoagulant education record

Medicine: ....
Education
Provided ☐ Declined ☐
Not appropriate ☐
Written information
Provided ☐ Declined ☐
Written information provided:
CMI ☐ Other: ☐ ....
Signature: ....
Designation: .... Date: ....

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 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	
Prescriber signature	SAC/AAN	

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

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

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

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

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

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

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

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

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

Start Date ...... /	Medicine (print generic name)/form	Tick if slow release
Route	Dose *and* Frequency and now enter times →	
Indication	Pharmacy	
Prescriber signature	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