

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

Approved pharmacy details:

 Pharmacy approval no:

Attach ADR sticker

See front page for details

First prescriber to print patient name and check label correct:

As required PRN medicines

Brand substitution not permitted PBS/RPBS

Year

Start Date	Medicine (print generic name)/form	Date	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time
..... /																				
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																		
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Prescriber signature		Sign																		
Pharmaceutical review:																				

DO NOT WRITE IN THIS BINDING MARGIN

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Check if patient has another medication chart

Cut off section

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

Medication chart numberof

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		Prescriber/nurse initiator name	Prescriber/nurse initiator sign	Date	Record of administration				Pharmacy
					N1	N2				Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by	

Document admission medications on Medication Management Plan HRxxx

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 B (Acute)

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

Cut off section

Attach ADR sticker

Affix patient identification label here and overleaf

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

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

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

Route Frequency Prescriber to enter dose times and individual dose

Indication Pharmacy Prescriber

Prescriber signature SAC/AAN Nurse initial

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

Start Date	Medicine (print generic name)/form	Route	Dose and Frequency	Indication	Pharmacy	Prescriber	SAC/AAN	AM check	PM check	Continue on discharge? Y / N	Dispense? Y / N	Duration: days Qty:	Prescriber's signature	Date:
..... /				VTE prophylaxis										

Mechanical prophylaxis

Signature / NI signature Print name

Warfarin Marevan / Coumadin INR Result

Start Date	Medicine (print generic name)/form	Target INR Range	Dose	Continue on discharge? Y / N	Dispense? Y / N	Duration: days Qty:	Prescriber's signature	Date:
..... /			mg mg mg mg mg mg mg mg mg mg mg mg					

Route Prescriber to enter individual doses

Indication Pharmacy Prescriber

Initial 1 18:00 Initial 2

Prescriber to enter administration times →

Start Date	Medicine (print generic name)/form	Route	Dose and Frequency	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	Route	Dose and Frequency	Indication	Pharmacy	Prescriber signature	SAC/AAN	Continue on discharge? Y / N	Dispense? Y / N	Duration: days Qty:	Prescriber's signature	Date:
..... /												

Pharmaceutical review:

Recommended administration times
Guidelines only

Time	Code	Time	Time	Time	
Morning	Mane	0800	1800 or 2000		
Night	Nocte				
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

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

Prescriber to enter administration times →

Start Date	Medicine (print generic name)/form	Route	Dose and Frequency	Indication	Pharmacy	Prescriber signature	SAC/AAN	Continue on discharge? Y / N	Dispense? Y / N	Duration: days Qty:	Prescriber's signature	Date:
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Pharmaceutical review:

Check if patient has another medication chart

Check if patient has another medication chart