REMOVED AREA

REMOVED AREA

Paediatric Medication chart number: ______ of ______

Facility/service: ....

Ward/unit: ....

Additional charts

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

Once only medicines

Date prescribed	Medicine (print generic name)	Route	Dose	Dose calc eg. mg/kg per dose	Date/time to be given	Prescriber Signature	Prescriber Print your name	Given by	Date/time given	Pharm

Telephone orders (to be signed within 24 hours of order)

Date time	Medicine (print generic name)	Route	Dose	Dose calc eg. mg/kg per Dose	Frequency	Check initials N1	Check initials N2	Prescriber name	Pres. sign	Date	Record of administration: Time / given by	Time / given by	Time / given by

Medicines taken prior to presentation to hospital

(prescribed, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N

Medicine and formulation	Dose and frequency	Duration	Medicine and formulation	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Paediatric

NIMC (paediatric long-stay)

Paediatric

Not a valid order unless legible

Affix patient identification label here

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** ☐ **M** ☐ **F**

First prescriber to print patient name and check label correct: ....

Attach ADR sticker

See front page for details

As required PRN medicines

Weight (kg): ....

Date weighed: ....

Ward/unit: ....

Date	Medicine (print generic name)			Date										
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time										
Pharmacy/additional information				**Dose**										
Indication	**Dose** calculation (eg. mg/kg per dose)			Route										
Prescriber signature	Print your name	Contact/pager		Sign										

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

Date	Medicine (print generic name)			Date										
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time										
Pharmacy/additional information				**Dose**										
Indication	**Dose** calculation (eg. mg/kg per dose)			Route										
Prescriber signature	Print your name	Contact/pager		Sign										

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

Date	Medicine (print generic name)			Date										
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time										
Pharmacy/additional information				**Dose**										
Indication	**Dose** calculation (eg. mg/kg per dose)			Route										
Prescriber signature	Print your name	Contact/pager		Sign										

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

Date	Medicine (print generic name)			Date										
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time										
Pharmacy/additional information				**Dose**										
Indication	**Dose** calculation (eg. mg/kg per dose)			Route										
Prescriber signature	Print your name	Contact/pager		Sign										

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

Date	Medicine (print generic name)			Date										
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time										
Pharmacy/additional information				**Dose**										
Indication	**Dose** calculation (eg. mg/kg per dose)			Route										
Prescriber signature	Print your name	Contact/pager		Sign										

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

Prescriber's signature: .... Print your name: .... Pager: .... Date: .... Pharmacist: .... Date: ....

DO NOT WRITE IN THIS BINDING MARGIN

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**

First prescriber to print patient name and check label correct:

Weight (kg): ....

Date weighed: ....

Height (cm): .... BSA (m²): ....

Gestational age at birth (wks): ....

REMOVED AREA

Regular medicines

Year 20 .... **Date and month** →

PRESCRIBER MUST ENTER administration times

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	Frequency and NOW enter times
Pharmacy/additional Information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	Frequency and NOW enter times
Pharmacy/additional Information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	Frequency and NOW enter times
Pharmacy/additional Information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	Frequency and NOW enter times
Pharmacy/additional Information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Date	Medicine (print generic name)	Tick if slow release
Route	**Dose**	Frequency and NOW enter times
Pharmacy/additional Information		
Indication	Dose calculation (eg. mg/kg per dose)	
Prescriber signature	Print your name	Contact/pager

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

Pharmaceutical review:

Prescriber's signature: .... Print your name: .... Pager: .... Date: .... Pharmacist: .... 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 not administering
Codes MUST be circled

Reason	Code
Absent	A
Fasting	F
Refused—notify prescriber	R
Vomiting	V
On leave	L
Not available—obtain supply or contact prescriber	N
Withheld—enter reason in clinical record	W
Self administered	S
Parent/carer administered	P

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