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 (m^2): .....

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

REMOVED AREA

SECTION A

REMOVED AREA

REMOVED AREA

SECTION A

REMOVED AREA

Ward/unit: .....

Paediatric Medication chart number ___ of ___

Additional charts

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

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Paediatric NIMC (paediatric long-stay) private hospital Paediatric

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: .....

Not a valid order unless legible

Date	Medicine (print generic name)				Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
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											
Date	Medicine (print generic name)				Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pharmacist: .....
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											
Date	Medicine (print generic name)				Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Pager: .....
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											
Date	Medicine (print generic name)				Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Print your name: .....
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											
Date	Medicine (print generic name)				Date										Continue on discharge? Yes / No Dispense? Yes / No Duration: ..... days Qty:	Date: ..... Prescriber's signature: .....
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											

DO NOT WRITE IN THIS BINDING MARGIN

REMOVED AREA

SECTION B

Pharmacy prescription

Date
Patient name
1st 2nd
☐ PBS
☐ RPBS
(✓) Appropriate box

Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted

Indication
Medicare Australia/DVA copy – valid for use as PBS at:
Dose calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date
Patient name
1st 2nd
☐ PBS
☐ RPBS
(✓) Appropriate box

Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted

Indication
Medicare Australia/DVA copy – valid for use as PBS at:
Dose calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date
Patient name
1st 2nd
☐ PBS
☐ RPBS
(✓) Appropriate box

Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted

Indication
Medicare Australia/DVA copy – valid for use as PBS at:
Dose calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

Pharmacy prescription

Date
Patient name
1st 2nd
☐ PBS
☐ RPBS
(✓) Appropriate box

Medicine (print generic name)
Tick if slow release
Route
Dose
Frequency and NOW enter times →
☐ Brand substitution not permitted

Indication
Medicare Australia/DVA copy – valid for use as PBS at:
Dose calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

Pharmacy prescription

REMOVED AREA

SECTION C

Pharmacy prescription

Date	Patient name 1st 2nd					☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route		**Dose**	Frequency and NOW enter times →	
Indication	Pharmacist/patient copy – valid for use with PBS Repeat Authorisation			**Dose** calculation (eg. mg/kg per dose)		
Prescriber name	Prescriber No	Prescriber signature		Contact	Quantity	Repeats

Pharmacy prescription

Pharmacy prescription

Date	Patient name 1st 2nd					☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route		**Dose**	Frequency and NOW enter times →	
Indication	Pharmacist/patient copy – valid for use with PBS Repeat Authorisation			**Dose** calculation (eg. mg/kg per dose)		
Prescriber name	Prescriber No	Prescriber signature		Contact	Quantity	Repeats

Pharmacy prescription

Pharmacy prescription

Date	Patient name 1st 2nd					☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route		**Dose**	Frequency and NOW enter times →	
Indication	Pharmacist/patient copy – valid for use with PBS Repeat Authorisation			**Dose** calculation (eg. mg/kg per dose)		
Prescriber name	Prescriber No	Prescriber signature		Contact	Quantity	Repeats

Pharmacy prescription

Pharmacy prescription

Date	Patient name 1st 2nd					☐ PBS ☐ RPBS (✓) Appropriate box
Medicine (print generic name) ☐ Brand substitution not permitted	Tick if slow release	Route		**Dose**	Frequency and NOW enter times →	
Indication	Pharmacist/patient copy – valid for use with PBS Repeat Authorisation			**Dose** calculation (eg. mg/kg per dose)		
Prescriber name	Prescriber No	Prescriber signature		Contact	Quantity	Repeats

Pharmacy prescription

REMOVED AREA

SECTION D

Regular medicines

Year 20 ..... **Date and month** →

PRESCRIBER MUST ENTER administration times →

DO NOT WRITE IN THIS BINDING MARGIN

Not a valid order unless legible

Prescriber: please press firmly – pharmacy prescriptions underneath

Date | Patient name 1st 2nd | ☐ PBS ☐ RPBS (✓) Appropriate box

Medicine (print generic name) | Tick if slow release | Route | **Dose** | Frequency and NOW enter times →

☐ Brand substitution not permitted

Indication | Pharmacy | **Dose** calculation (eg. mg/kg per dose)

Prescriber name | Prescriber No | Prescriber signature | Contact | Quantity | Repeats

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

Date: .....

Pharmacist: .....

Date: .....

Pager: .....

Print your name: .....

Prescriber's signature: .....

Pharmaceutical 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 not administering Codes MUST be circled	
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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