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Paediatric **Medication chart number:** ..... **of** .....

Facility/service: .....

Ward/unit: .....

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**	Date/time to be given	Prescriber: Signature / Print your name	Dose calc eg. mg/kg per Dose	Given by	Date / time given	Pharm

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

Date time	Medicine (print generic name)	Route	**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	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**

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	Date:
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time	Dispense? Yes / No	
Pharmacy/additional information				**Dose**	Duration: ..... days Qty:	Pharmacist:
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	Date:
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time	Dispense? Yes / No	
Pharmacy/additional information				**Dose**	Duration: ..... days Qty:	Pharmacist:
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	Date:
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time	Dispense? Yes / No	
Pharmacy/additional information				**Dose**	Duration: ..... days Qty:	Pager:
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	Date:
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time	Dispense? Yes / No	
Pharmacy/additional information				**Dose**	Duration: ..... days Qty:	Print your name:
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	Prescriber's signature:
Route	**Dose**	Hourly frequency **PRN**	Max PRN dose/24 hrs	Time	Dispense? Yes / No	
Pharmacy/additional information				**Dose**	Duration: ..... days Qty:	
Indication	**Dose** calculation (eg. mg/kg per dose)			Route		
Prescriber signature	Print your name	Contact/pager		Sign		

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 (m^2): .....

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

REMOVED AREA

Regular medicines

Year 20 .....

Date and month →

PRESCRIBER MUST ENTER administration times

Each medicine block:

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: .....

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

Date: .....

Pharmacist: .....

Date: .....

Pager: .....

Print your name: .....

Prescriber's signature: .....

Pharmaceutical review:

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