# National Inpatient Medication Chart

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:

**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 ____

**Medication chart number** ____ of ____

Facility/service: ____ Ward/unit: ____

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

## Once only and nurse initiated medicines and pre-medications

| Date prescribed | Medicine (print generic name) | Route | Dose | Date/time of dose | Prescriber/Nurse Initiator (NI) Signature | Prescriber/Nurse Initiator (NI) Print your name | Given by | Time given | Pharmacy |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## 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 Administration aid (specify) ____

| Medicine | Dose and frequency | Duration | Medicine | Dose and frequency | Duration |
|---|---|---|---|---|---|
| | | | | | |

GP: Community pharmacy:

Sign: Print: Date: Medicines usually administered by:

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**Allergies and adverse drug reactions**
See page 1 for details

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)

| | |
|---|---|
| (A) Absent | (L) On leave |
| (F) Fasting | (N) Not available obtain supply or contact prescriber |
| (R) Refused notify prescriber | (W) Withheld enter reason in clinical record |
| (V) Vomiting | (S) Self administered |

**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 |

**Anticoagulant education record**
Medicine: Education Provided? ☐ Declined ☐ Not appropriate ☐ Written information Provided? ☐ Declined ☐ Written information provided: CMI ☐ Other ☐ Signature: Designation: Date:

## Regular medicines

Year 20 ____ Date and month →

**Variable dose medicine**
Date | Medicine (print generic name) | Drug level | Time level taken
Route | Frequency | Dose
Prescriber to enter dose times and individual dose | Prescriber
Indication | Pharmacy | Time to be given:
Prescriber signature | Print your name | Contact | Time given

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

**VTE prophylaxis**
Date | Medicine (print generic name)
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact
Mechanical prophylaxis
Prescriber/NI signature | Print your name | Contact

**Warfarin** Marevan / Coumadin select brand
Date | 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 | Print your name | Contact | 1600 Initial 1 Initial 2

AM check
PM check

**PRESCRIBER MUST ENTER administration times**
Date | Medicine (print generic name) | Tick if slow release
Route | Dose | Frequency and NOW enter times →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Pharmacist: Date: Print your name: Prescribers signature: Date:

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## 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 →
Indication | Pharmacy
Prescriber signature | Print your name | Contact

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

Pharmacist: Date: Print your name: Prescribers Signature:

**Pharmaceutical review:**

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See page 2 for details

## As required PRN medicines

Year: 20 ____

Date | Medicine (print generic name)
Route | Dose | Hourly frequency | Max PRN dose/24 hrs | PRN
Indication | Pharmacy
Prescriber signature | Print your name | Contact

Time | Dose | Route | Sign

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

Pharmacist: Date: Print your name: Prescribers Signature:

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